DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
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Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

FEB 0 7 2013

Chris Traylor
Deputy Executive Commissioner, Office of Health Services
Texas Health and Human Services Commission
11209 Metric Blvd, Building H, Mail Code H100 PO Box 85200
Austin, TX 78758

Dear Mr. Traylor:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your revised evaluation for Texas's section 1115 demonstration project, entitled Texas Healthcare Transformation and Quality Improvement Program (Project Number 11-W-00278/6).

As described in special term and condition (STC) 70, the state must implement its evaluation plan and submit its progress in each quarterly and annual report. In addition to a final evaluation report, this evaluation plan requires quarterly reports to CMS and an interim evaluation report in order to support rapid cycle improvement and continuous quality improvement, particularly for providers participating in the Delivery System Reform Incentive Payment (DSRIP) program.

As described in attachment J of the STCs, if the state's external evaluator identifies data problems or other concerns during its review of DSRIP projects, it may require providers to submit plan modifications for HHSC and CMS review.

Your project officer is Mr. Robert Nelb. He is available to answer any questions concerning your section 1115 demonstration. Mr. Nelb's contact information is as follows:

> Centers for Medicare & Medicaid Services
> Center for Medicaid, and CHIP Services
> Division of State Demonstrations and Waivers
> 7500 Security Boulevard
> Mail Stop S2-02-26
> Baltimore, MD 21244-1850
> Telephone: (410) 786-1055
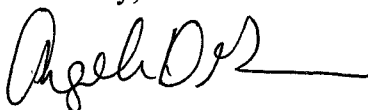> Facsimile: (410) 786-8534
> E-mail: robert.nelb@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Nelb and to Mr. Bill Brooks, Associate Regional Administrator in our Dallas Regional Office. Mr. Brook's address is:

Bill Brooks
Centers for Medicare & Medicaid Services
1301 Young St. Suite 714
Dallas, TX 75202
Telephone: (214) 767-4461
E-mail: Bill.Brooks@cms.hhs.gov

If you have questions regarding this approval, please contact Ms. Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, Center for Medicaid, and CHIP Services, at (410) 786-5647.

Sincerely,

Angela D. Garner
Deputy Director
Division of State Demonstrations and Waivers

Enclosures

cc: Bill Brooks, Associate Regional Administrator, Region VI

Texas Healthcare Transformation and Quality Improvement Program Demonstration Waiver

Evaluation Plan

Texas Health and Human Services Commission
Strategic Decision Support
November 16, 2012

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EVALUATION PURPOSE

The Texas Healthcare Transformation and Quality Improvement Program (Program) is a Section 1115(a) waiver demonstration approved by the U. S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) on December 12, 2011. The Demonstration started December 12, 2011 and will end September 30, 2016. The Texas Health and Human Services Commission (HHSC) Medicaid/CHIP Division is managing the implementation and oversight of the Program.

The overarching goal of the Program is to support the development and maintenance of a coordinated care delivery system, thereby maintaining or improving health outcomes while containing cost growth. The Program strategy uses **two types of interventions** to achieve the overarching goal:

1) expanding the existing Medicaid managed care programs, STAR and STAR+PLUS, statewide, creating a new children's dental program, while carving-in prescription drug benefits; and

2) establishing two funding pools that will assist providers with uncompensated care costs and promote health system transformation.

The Program evaluation will examine the implementation and impact of the two Program interventions through a set of quarterly and annual performance measures throughout the demonstration period (December 12, 2011 through September 30, 2016). The principal focus of the demonstration evaluation will be on obtaining and monitoring data on performance measures for short-term (process measures) and intermediate (health outcomes) of the Program. The performance measures will be used to assess the extent to which the Program accomplishes its goals, track changes from year to year, and identify opportunities for improvement.

DESCRIPTION OF DEMONSTRATION EVALUATION

The following section provides a general description and evaluation goals for the two Program interventions. However, detailed information regarding Program description can be found in the 1115 Waiver.[1]

Intervention 1: Expansion of Medicaid Managed Care Program Statewide

The first intervention relates to the expansion of the Medicaid Managed Care program statewide. Expansion activities include:

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[1] http://www.hhsc.state.tx.us/Waiver-1115-proposal.pdf. Last accessed November 5, 2012.

- Expand risk-based managed care delivery system (STAR and/or STAR+PLUS) statewide replacing the primary care case management (PCCM) or fee-for-service (FFS) delivery systems.

- Replace the FFS delivery model for delivering primary and preventive dental care with a managed care model (children's Medicaid dental services).

- Prescription drug benefits, previously provided under the FFS program, will be carved into managed care benefit and capitation rates.

STAR provides services in a managed care delivery system and focuses on acute care and early prevention. Through the waiver, STAR expanded to two new service delivery areas (SDAs). The Hidalgo SDA includes 10 counties in South Texas and has a confirmed total enrollment of 319,763.[2] The Medicaid Rural Service Area (MRSA) includes 164 counties and has a confirmed enrollment of 419,430.[3] The STAR+PLUS program integrates acute care and long-term care services and supports into a Medicaid Managed Care delivery system for people over the age of 65 years, who are blind, or who have disabilities. STAR+PLUS expands to SDAs in Lubbock (11,309 confirmed total enrollment) and El Paso (24,137 confirmed total enrollment) and a new Hidalgo (74,171 confirmed total enrollment) service area. The newly created STAR and STAR+PLUS SDAs will be the primary focus of this evaluation. As members shift from PCCM or FFS to a capitated managed care system it creates an ideal situation to examine the impact of managed care expansion on access to care, coordination of care, quality of care, and cost.

Impact of Managed Care Expansion

The evaluation goals under this domain relate to the impact of managed care expansion on access to care, coordination of care, quality of care, efficiency of care, and cost of care.

- **Evaluation Goal 1:** Evaluate the extent to which *access to care* improved through managed care expansion to new STAR and STAR+PLUS SDAs.

    o Program focus goals include, but are not limited to, access to prescription drugs, dental care for children, non-behavioral inpatient care, adult access to preventative/ambulatory health service, and prenatal and postpartum care (PPC).

- **Evaluation Goal 2:** Evaluate the extent to which *coordination of care* improved through managed care expansion to new STAR and STAR+PLUS SDAs.

    o Program focus goals include, but are not limited to, coordination of care among providers and service coordination.

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[2] All enrollment data is from Texas Enrollment Broker Confirmed Eligibles Report for October 2012. Accessed at http://www.hhsc.state.tx.us/medicaid/mc/about/reports/confirmed_eligible/201209.pdf
[3] All enrollment data is from Texas Enrollment Broker Confirmed Eligibles Report for October 2012. Accessed at http://www.hhsc.state.tx.us/medicaid/mc/about/reports/confirmed_eligible/201209.pdf

- **Evaluation Goal 3:** Evaluate the extent to which *quality of care* improved through managed care expansion to new STAR and STAR+PLUS SDAs, Dental Services, and Pharmacy Services.

  - o Program focus goals include, but are not limited to, quality of dental care for children, effects of automatic re-enrollment after disenrollment, and quality of adult preventive and emergent care.

- **Evaluation Goal 4:** Evaluate the extent to which *efficiency improved and cost decreased* through managed care expansion to new STAR and STAR+PLUS SDAs, and Dental Services.

  - o Program focus goals include, but are not limited to, reduction of member costs, increased utilization rates, and an analysis of the experience rebate provision.

Intervention 2: Formation of Regional Healthcare Partnership (RHP) Regions

CMS requires a state seeking a Section 1115 waiver to establish that federal expenditures will not be greater than they would be under the state plan. To meet that requirement, the Program calculated the projected savings from the expansion of managed care and the amount of hospital funding historically received as Upper Payment Limit (UPL) payments, which together establish the maximum amount of funding available to pay providers through the waiver. That amount was allocated to two new funding pools. The Uncompensated Care (UC) and Delivery System Reform Incentive Payment (DSRIP) pools aim to assist hospitals and other providers with uncompensated care costs and to promote health system transformation in preparation for new coverage demands beginning in 2014. To receive payments from either funding pool, a hospital must join with other hospitals or public entities in a geographic region to form Regional Healthcare Partnerships (RHP). Each RHP, with the collaboration of participating providers, will identify performance areas for improvement and create a plan under which its members will implement approved projects to achieve waiver goals. Projects eligible for incentive payments must come from a menu of projects approved by CMS and HHSC, and have corresponding metrics and milestones.[4] The lessons learned from the development of these sustainable networks of hospitals and providers are of particular interest.

Uncompensated Care Costs

The evaluation goal under this domain relates to examining the distribution of uncompensated care funds to hospitals and other provider types.

The UC pool is designed to help defray uncompensated costs of care provided for Medicaid or Demonstration eligibles or to individuals who have no source of third party coverage for the services provided by hospitals or other providers. To receive payments from the UC

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[4] For more information on the menu of approved project types, and the metrics and milestones see: http://www.hhsc.state.tx.us/1115-Waiver-Guideline.shtml.

pool, a hospital must complete an application listing its uncompensated costs for services provided to Medicaid and uninsured individuals. A hospital may claim uncompensated costs for inpatient and outpatient services, as well as related costs for physician, clinic, and pharmacy services. While it is not expected that the need for UC funds will decrease, it is expected that as the health system transforms due to the DSRIP projects, the rate at which the need grows will slow due to the improved services and supports.

- **Evaluation Goal 5:** Evaluate whether the amount of claims for uncompensated costs, based on service type, remains stable or decreases over time for hospitals participating in the waiver.

Delivery System Reform Incentive Payment Pool

The evaluation goals under this domain relate to the ability of the RHPs to show, through the utilization of DSRIP funds, quantifiable improvements relating to quality of care, population health, and cost of care. The goals also relate to the increased collaboration among health care organizations and stakeholders in each region due to the establishment of the RHPs.

The DSRIP pool is designed to incentivize activities that support a region's collaborative efforts to improve access to care, the quality of care, and improve the health of the patients and families they serve. To receive payments from the DSRIP pool, a hospital must meet specific metrics for each project selected by the RHP members and detailed in the plan. Projects using funds from the DSRIP pool must be directed toward activities which are divided into four interrelated and complementary categories: infrastructure development, program innovation and redesign, quality improvements, or population-focused improvements.

- **Evaluation Goal 6:** Evaluate the extent to which, through the implementation of DSRIP projects, RHPs impacted the quality of care.

- **Evaluation Goal 7:** Evaluate the extent to which, through the implementation of DSRIP projects, RHPs impacted the health of the population served.

- **Evaluation Goal 8:** Evaluate the extent to which, through the implementation of DSRIP projects, RHPs impacted the cost of care.

- **Evaluation Goal 9:** Evaluate the extent to which the establishment of RHPs increased collaboration among health care organizations and stakeholders in each region.

Stakeholder Input

The evaluation goals under this domain relate to stakeholder perceptions of the expanded managed care program, the UC pool, and the DSRIP pool. Stakeholders will include individuals and families, advocacy groups, providers, health plans, and hospital administrators.

- **Evaluation Goal 10:** Assess stakeholder-perceived strengths and weaknesses, and successes and challenges of the expanded managed care program, the UC pool, and the DSRIP pool to improve operations and outcomes.

- **Evaluation Goal 11:** Assess stakeholder-recommended changes to the expanded managed care program, the UC pool, and the DSRIP pool to improve operations and outcomes.

EVALUATION DESIGN

Given that there are two interventions in the Demonstration, there will be two program evaluations. The evaluation design for assessing overall programmatic impact associated with implementation of the Waiver is described using two logic models (see Figures 1 and 2). These program logic models describe the organization and explanation for the program evaluations. Fundamentally, the logic models assisted evaluators in narrowing the focus of the evaluation to questions that demonstrate whether or not the process of program expansion was successful, whether there was an impact on maintaining or improving the health status of Texas Medicaid Managed Care members while containing cost growth, and whether the establishment of the two funding pools promote health system transformation.

A research design was selected for each of the interventions to provide the best available information and cost-effectively address the evaluation questions. Each intervention is described with a logic model which describes how the Program is expected to change healthcare delivery in the short- and intermediate-term. Each logic model links the federal, state, and local stakeholders involved, process indicators (which may include Program or organizational changes) and how changes may influence intermediate health outcomes. The next sections align the two logic models with metrics and methodology used for analyses.

Intervention 1: Expansion of Medicaid Managed Care Program Statewide (Evaluation Goals 1 – 4)

Given the Program expansion activities described in the program description, the evaluation will include measures on short-term outcomes (process indicators), intermediate outcomes (health outcome indicators), and cost outcome indicators (see Figure 1). Process indicators will include measures of care coordination, member satisfaction, and preventive care-specific clinical processes shown to be associated with favorable clinical outcomes. Health outcome measures will include measures of clinical outcomes that are associated with process indicators. Finally, cost outcome indicators associated with process and health outcome indicators will be examined for any changes due to process or health outcome measures.

Over the five-year demonstration period (DP), measures on process (short-term), health outcome indicators (intermediate), and cost outcome indicators will be reported quarterly and in the interim and final evaluation reports. However, Texas anticipates that changes will first be observed in process outcomes and then in intermediate outcomes in later

demonstration years. By monitoring process outcomes, we expect to reduce the likelihood of false negative results due to time period for detecting any health outcome being too short.

Even though the overarching long-term impact is to maintain or improve health outcomes while containing cost growth, Texas will focus on evaluating each process and associated health outcome. The advantage of this strategy enables Texas and CMS to examine differences among specific health benefits (e.g., prescription drugs) in order to identify which benefit may be making the greatest positive impact and which health benefit deserves improvement.

Trend Analysis

A pre- and post- expansion design will be developed to evaluate the expansion of Medicaid Managed Care program into the new SDAs due to concerns over establishing adequate comparison group(s). A pre- and post- intervention design will involve collecting information only on the expanded service areas (Hidalgo, El Paso, Lubbock, and MRSA) and may include analysis at the member, county, managed care organization (MCO), or SDA-level. Data will be collected at least twice:

- Before expansion – data collected once before the expansion (or intervention) will provide baseline data. Baseline data is ideally defined as data 3-years prior to expansion (under FFS system or PCCM).

- After expansion – depending on the performance measure/indicator, data may be collected quarterly, annually, or on specific demonstration years.

Unless specified, data will be collected to monitor and track process (short-term) outcomes and health outcomes indicators (intermediate outcomes) over the demonstration period. However, it is important to note that a trend analysis does not provide direct evidence that would allow program officials or policy makers to attribute any specific changes to the Program. Because trend analysis uses cross-sectional data, it does not provide strong evidence for cause and effect. Any findings may be limited to associations only.

Additional Analyses

For each health outcome (intermediate outcome) benefit, the evaluation will examine the relationship between process indicators (short-term outcomes) and health outcome (intermediate outcomes). Depending on how the performance measure is measured (i.e., nominal, ordinal, or interval) and the unit of analysis (i.e., member, counter, MCO, or SDA-level), contingency tables (case-control) will be described.

Figure 1. Logic Model for the Medicaid Managed Care Expansion Intervention
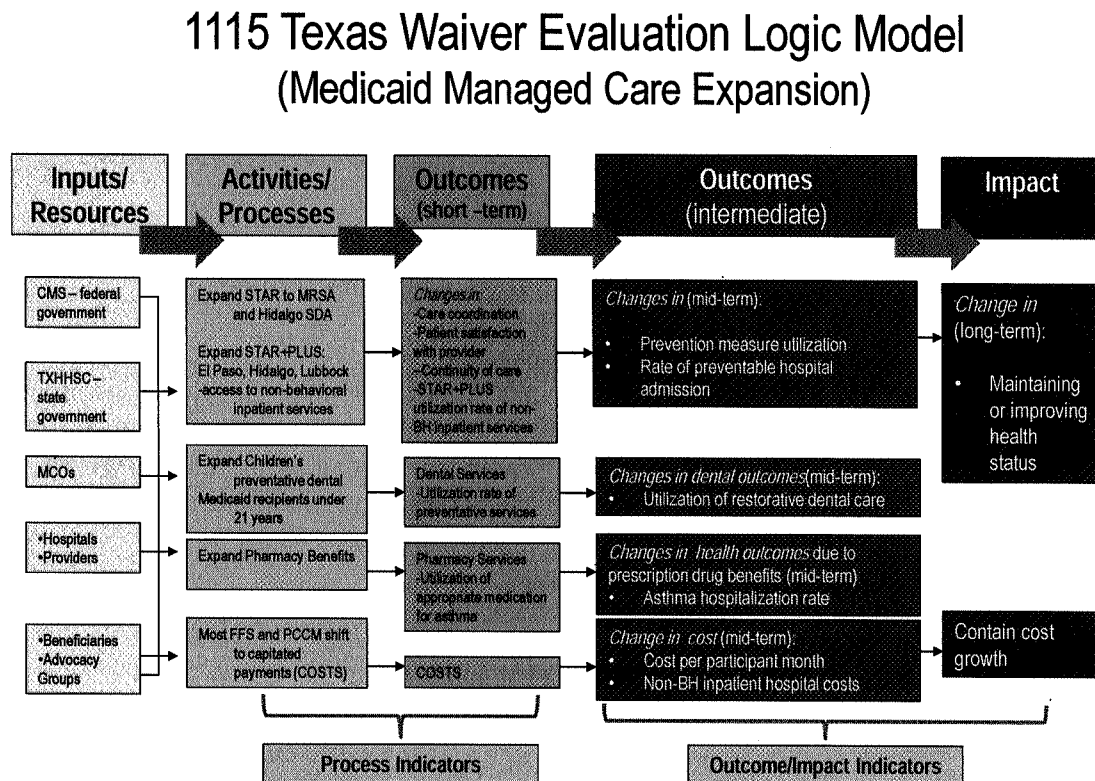
Data Collection

For the first intervention, information is provided on data sources, how these data are to be used, and the methods related to the evaluation questions. The data collected to examine the impact of the Medicaid Managed Care program expansion statewide come from three basic sources. This section describes the data sources used to evaluate the first intervention. After the data sources have been described, each evaluation question will be addressed along with related hypothesis and any additional analyses not previously mentioned.

1. <u>Health Employer Data and Information Set (HEDIS)</u>® was adopted by the National Committee for Quality Assurance (NCQA) as a standard of performance measures used by more than 90 percent of national health plans. Participation in HEDIS® is required for plans seeking NCQA accreditation and most managed care plans allow NCQA to publish their annual HEDIS® data publicly. HEDIS® measures focus on preventative and primary care services for defined populations of health plan enrollees. While HEDIS® measures may be interpreted as measures of managed care performance, there are a few measures that reflect the performance of hospital or multi-hospital systems.

   Three data sources were used to calculate the HEDIS quality of care indicators:

   o **Member-level enrollment files** - The enrollment files contain information about the person's age, gender, the MCO in which the member is enrolled, and the number of months the member has been enrolled in the program.

   o **Member-level health care claims/encounter data** - The member-level claims/encounter data contain the Current Procedural Terminology (CPT) codes, and International Classification of Diseases, 9th Revision (ICD-9-CM) codes, place of service (POS) codes, and other information necessary to calculate the quality of care indicators. There is a six-month time lag for claims and encounter data. Prior analyses with Texas data have shown that, on average, over 96 percent of claims and encounters are complete by that time period.

   o **Member-level pharmacy data** - The member-level pharmacy data contain information about filled prescriptions, including the drug name, dose, date filled, number of days prescribed, and refill information.

2. <u>Consumer Assessment of Health Plans Survey (CAHPS)</u>© was developed by the Agency for Healthcare Research and Quality (AHRQ) to standardize patient surveys that can be used to compare results across sponsors over time. CAHPS© surveys ask patients to report on their experiences with a range of health care services at multiple levels of the delivery system.

   Texas CAHPS© participants are selected from a random sample of members and stratified by health plan. To be eligible for survey participation, member must have been enrolled in STAR or STAR+PLUS program for nine months or longer. Members who are eligible for both Medicaid and Medicare, and members who participated in the previous fiscal years' survey are excluded. Since October 1995, Texas has been contracting with an External Quality Review Organization (EQRO), the University of Florida, Institute for Child Health Policy to implement and report on CAHPS© data. Each year, a target total of survey participants is established and contacted by telephone.

3. <u>Managed Care and Fee-for-Service Encounter Data</u> FFS and Managed Care encounter data have been processed by the Texas Medicaid and Healthcare Partnership (TMHP)

since January 1, 2004. TMHP (headed by contractor Xerox State Health Services) performs internal edits for data quality and completeness. There is a six-month time lag for claims and encounter data. Prior analyses with Texas data showed that, on average, over 96 percent of the claims and encounters are complete by that time period.

Evaluation Questions

The evaluation questions are broken down into three evaluation measurement types: Process indicators (short-term), health outcome indicators (intermediate), and cost outcome indicators. Table 1 presents a summary of each evaluation question including the performance measure/indicator, the data source, anticipated outcome, and deliverable timeline.

Process Indicators

Evaluation questions specifically having to do with process indicators are described below.

1. Did expansion of STAR to the Hidalgo SDA and STAR+PLUS to the El Paso, Hidalgo, and Lubbock SDAs impact access to care for the target population? (STC 68.a.i)

   o *Adult access to preventive/ambulatory health services.* As Medicaid managed care is expanded through the STAR and STAR+PLUS delivery systems, the number of preventive or ambulatory care visits by plan members will be measured and monitored. As members formerly receiving benefits under FFS or PCCM move into STAR or STAR+PLUS, it is expected that the number of members who receive preventive or ambulatory health services will increase.

   Methods. HEDIS® measures will be obtained annually by MCO and SDA over the demonstration years and compared to baseline years.

2. What was the impact (access, quality of care, and program costs) of including non-behavioral hospital inpatient services in the STAR+PLUS program? (STC 68.a.i.E)

   o *Number of STAR+PLUS members who had inpatient hospital stays.* The carve-in of non-behavioral health inpatient services to the STAR+PLUS managed care benefit program will enable members to have covered access to non-behavioral health inpatient services through the capitated system rather than through a FFS system. Access to inpatient services will be measured by monitoring the rate of inpatient hospitalizations over the demonstration period for STAR+PLUS members in El Paso, Hidalgo, and Lubbock SDAs.

   Methods. Managed Care and FFS claims and encounter data will be used to determine the number of STAR+PLUS members who had inpatient hospital stays in a demonstration year per 1,000 members. The data will be reported by MCO and SDA over the demonstration years and compared to baseline years.

o ***Services utilized during hospitalizations.*** Services utilized during hospitalizations potentially indicate the quality of healthcare received. If top procedures performed include a high number of potentially avoidable conditions, this may indicate deficiencies in the quality of care.

  Methods. Managed Care and FFS claims and encounter data will be used to determine the top ten procedures performed on inpatient admissions and will be monitored and compared to baseline years and AHRQ national rates. These rates will be reported by MCO and SDA over demonstration years and compared to baseline years.

o ***Average number of miles from STAR+PLUS members to closest participating inpatient hospital in each new service area.*** The expectation is that that members will continue to have similar access to inpatient services as before the expansion.

  Methods. A distance analysis of inpatient hospitals participating in STAR+PLUS programs will be compared with a distance analysis of hospitals that submitted claims under the FFS and PCCM systems in the three years prior to expansion of managed care for each new SDA. These rates will be reported by MCO and SDA over the demonstration years and compared to baseline years.

o ***Program financing.*** It is expected that the average cost of hospitalizations for STAR+PLUS members in El Paso, Hidalgo, and Lubbock SDAs will be less than the average cost of hospitalizations in the same service areas prior to the expansion (under FFS).

  Methods. Managed Care and Fee-for-Service Encounter Data will be used to determine the average cost of hospitalization for STAR+PLUS members who had inpatient hospital stays in a demonstration year compared to the baseline years. The data will be reported by MCO and SDA over the demonstration years and compared to baseline years.

3. Has the utilization of preventative (and care coordination) of dental services for children age 20 years and younger changed as a result of the expansion? (STC 68.a.i.B)

  o ***Participating children's access to dental services.*** As children's dental care benefits are expanded through a capitated statewide dental services model (children's Medicaid dental services), access to dental care for plan members will be measured and monitored over the demonstration period.

    Methods. Unduplicated counts of members and those receiving services will be obtained from Children's Medicaid dental services enrollment database and monthly Medicaid encounters data. The data will be compared with results for the same age children from the national data from National Survey of Children's Health and EPSDT FFS results from baseline years.

o *Participating children's use of recommended preventive dental services.* As children's dental care benefits are expanded through capitated statewide dental services (children's Medicaid dental services), use of recommended preventive dental services will be measured and monitored over the demonstration period.

Methods. Recommended dental preventative services are based on the American Academy of Pediatric Dentistry and beginning at one year old include: 1) two dental check-ups in one calendar year, 2) receiving at least one fluoride treatment or dental cleaning in one calendar year, and 3) receiving at least one diagnostic dental service in one calendar year. Seven age cohorts will be constructed: 1) members < 1 year old; 2) members 1 to 2 years old; 3) members 3 to 5 years old; 4) members 6 to 9 years old; 5) members 10 to 14 years old; 6) members 15 to 18 years old; and 7) members 19 to 20 years old. These seven age cohorts are based on EPSDT age breakdowns and allow adequate pre- and post- expansion comparisons to baseline data.

4. Has the carve-in of pharmacy benefits into capitated managed care impacted access to care for the target population? (STC 68.a.i.A)

o *Access to prescription drug benefits.* As prescription drug benefits are carved-in to the capitated managed care benefits program, access to pharmacy benefits for plan members will be measured and monitored. Texas intends to examine access to prescription drugs for members with specific chronic health conditions.

Methods. Texas will identify members in select counties with prescriptions for asthma by using the NCQA list of appropriate medications for people with asthma. Access to pharmacy benefits will be measured as follows.
   i. Monitor and track stratified by age.
   ii. Use of appropriate medication for people with asthma (all ages).
   iii. *Limitations*: Although Texas will be tracking whether members received prescribed medications, we cannot know if members filled all recommended prescriptions from their physicians, or are using medications appropriately or at all. There might also be other environmental factors (potential confounders) that we cannot control for in any potential multivariate statistics.

5. Did expansion of STAR and STAR+PLUS to new service delivery areas impact care coordination for the target population? (STC 68.a.i)

o *Percent of STAR or STAR+PLUS members in each new service area who felt their doctor was informed about the care they received from other providers.* The expectation is that the number of managed care members who report that their doctor was informed about the care they received from other providers will remain stable or increase.

Methods. Data will be obtained from the annual member CAHPS© survey and information will be compared to pre-demonstration baseline years to capture any changes by service area results for clients receiving benefits under FFS or PCCM.

6. Did automatic re-enrollment after disenrollment for STAR, STAR+PLUS, and children's Medicaid dental services improve continuity of care for the target population? (STC 68.a.i.C)

   o *Automatic re-enrollment after disenrollment.* In order to improve continuity of care, STAR, STAR+PLUS, and children's Medicaid dental services members will be automatically reenrolled in their previous health plan after a period of ineligibility. Texas already has an auto-assignment algorithm for enrollment and disenrollment through the Enrollment Broker, MAXIMUS. Enrollees who do not select a plan within a specified period are auto-assigned with an MCO. Generally, the auto-assignment process considers an enrollee's history with a primary care provider or main dental provider in making an assignment. Measures of quality will focus on member satisfaction of their health care plan after they have been automatically reenrolled.

   Methods. Data will be obtained from MAXIMUS for at least one demonstration year. During one demonstration year, the number of members who requested a change to another MCO will be identified and stratified into three groups, 1) members who are newly enrolled, 2) members who automatically reenrolled after a lapse of less than three months, and 3) members who automatically reenrolled after a lapse of three months or more. For each group, data may be obtained on the frequency of MCO reassignment requests, reason(s) for request, and enrollee satisfaction. Depending on the availability of data, Texas anticipates examining any differences for each measure among the groups by using ANOVA unbalanced design (for quantitative outcomes, such as frequency of MCO reassignment requests) and chi-square contingency tables for nominal/ordinal outcomes, such as reason(s) for request and enrollee satisfaction.

Intermediate Health Outcome Indicators

Evaluation questions specifically having to do with health outcome indicators are described below. (STC 68.a.i.)

1. Did the expansion of STAR and STAR+PLUS to the new SDAs reduce preventable ER visits and hospitalizations over the demonstration period for the target population?

   Three measures will be monitored and tracked over the demonstration period for STAR and STAR+PLUS members in El Paso, Hidalgo, and Lubbock SDAs to determine whether access, quality of care, and care coordination is associated with reductions in potentially preventable emergency department and hospital admissions and readmissions. For this indicator, improved quality is shown by a decreasing trend of admission rates over the demonstration period.

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The movement of service delivery areas from FFS and PCCM into managed care is expected to improve care coordination and increase access to care by offering value-added components not available in FFS or PCCM. One aspect of quality is the prevention of visits to the emergency department and admissions to the hospital that were potentially avoidable with better access to care in the outpatient setting.[5] Potentially Preventable Events (PPEs) are inpatient stays, hospital readmissions, and emergency department (ED) visits that may have been avoidable had the patient received high quality primary and preventive care prior to or after the event in question. High PPE rates may reflect inadequacies in the health care provided to the patient in multiple settings, including inpatient and outpatient facilities and clinics.

- o *In each new service area, the number of potentially preventable emergency department visits per 1,000 members.* It is expected that members who receive regular preventative services through their primary care physician will show a decrease in potentially preventable emergency department visits in new managed care service areas.

  Methods. HEDIS® measures will be obtained annually by MCO and SDA over the demonstration years and compared to baseline years to determine if the rate of potentially preventable emergency department visits has decreased.

- o *In each new service area, the number of potentially preventable hospital admissions per 1,000 members.* It is expected that members who receive regular preventative services through their primary care physician will show a decrease in potentially preventable hospital admissions in new managed care service areas.

  Methods. HEDIS® measures will be obtained annually by MCO and SDA over the demonstration years and compared to baseline years to determine if the rate of potentially preventable emergency department visits has decreased.

- o *In each new service area, the number of potentially preventable readmissions per 1,000 members.* It is expected that members who receive adequate hospital care and post-hospital discharge follow-up through their physician will show fewer potentially preventable readmissions in new managed care service areas.

  Methods. HEDIS® measures will be obtained annually by MCO and SDA over the demonstration years and compared to baseline years to determine if the rate of potentially preventable emergency department visits has decreased.

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[5] According to measures developed for HEDIS®, potentially preventable emergency department visits and hospitalizations may include: general fever symptoms, including high fever; general chest pain symptoms, including chest discomfort, pressure, tightness, and burning, but excluding heart pain, heart disease symptoms, congestive heart failure; symptoms of mental status changes, like mood swings, wandering around, disorientation; gastrointestinal bleeding symptoms, including conditions such as blood in stool and vomiting blood; urinary tract infections; metabolic disturbance diseases, including such conditions such as low blood sugar, hypoglycemia, and poor nutrition; pneumonia, including viral, bacterial, and broncho pneumonia; diseases of the skin, including such conditions as cellulitis, seborrheic dandruff, eczema, psoriasis, and allergic skin reactions; and injuries due to falls.

2. Have dental MCOs reduced restorative dental care to the target population (children) over the demonstration period? (STC 68.a.i.B)

The children's Medicaid dental services program is expected to improve quality of care for enrolled children by increasing access to regular preventive care. Preventive care is a specific clinical process that has been shown to be associated with favorable clinical outcomes. It is expected that children who receive recommended preventative dental services will show a decreased need for restorative services. Seven age cohorts will be constructed: 1) members < 1 year old; 2) members 1 to 2 years old; 3) members 3 to 5 years old; 4) members 6 to 9 years old; 5) members 10 to 14 years old; 6) members 15 to 18 years old; and 7) members 19 to 20 years old. These seven age cohorts are based on EPSDT age breakdowns and allow adequate pre- and post- expansion comparisons.

- o *Number of members who received restorative dental services per 1,000 members.* It is expected that there will be an inverse relationship between members who receive regular preventive dental care and those receive restorative services. Restorative care is generally defined as the management of diseases of the teeth and supporting structures and the rehabilitation of their structure and function. Restorative treatments may include fillings, crowns, and the replacement of missing teeth.

  Methods. HEDIS® measures will be obtained annually by MCO and SDA over the demonstration years and compared to baseline years to determine if the rate of restorative dental services has decreased. Additional multivariate logistical analysis could examine the relationship between members who received regular preventative dental care on the likelihood that those members received restorative services. All data will be compared to national trends for the rate of restorative dental services.

3. Has the carve-in of pharmacy benefits into STAR and STAR+PLUS reduced the number of hospital admissions due to an acute asthmatic event? (STC 68.a.i.A)

- o *In each new service area, the number of asthma hospital admissions per 100,000 members.* It is expected that members who receive adequate prescription drugs for the care of this chronic illness will show fewer asthma hospital admissions.

  Methods. HEDIS® measures will be obtained annually by MCO and SDA over the demonstration years and compared to baseline years to determine if the rate of asthma hospital admissions has decreased. Additional multivariate logistical analysis could examine the relationship between members who received adequate prescription drugs for the care of asthma on the likelihood that those members have an asthma-related hospital admission.

Cost Outcome Indicators

The evaluation question specifically related to cost outcome indicators is described below.

1. How does Texas' Experience Rebate provision compare to Medical Loss Ratio regulation as a strategy for ensuring that managed care plans spend an appropriate amount of their premium revenue on medical expenses? Specifically, would the MCOs return approximately the same amounts to Texas under a Medical Loss Ratio requirement as under the Experience Rebate, or would the results differ? (STC 68.a.i.D)

   o *Amount of premium dollars returned to Texas under the Experience Rebate Provision.* Each MCO participating in either the STAR or STAR+PLUS programs must return to the state a portion of all profits over three percent of revenue based on a sliding scale. This is known as the Experience Rebate. In addition, the state imposes an administrative expense cap on all MCOs. The experience rebate is designed to ensure that MCOs are spending in an efficient manner and that profit and administrative costs are maintained. In contrast to Texas' Experience Rebate, the Affordable Care Act requires health insurance issuers to submit data on the proportion of premium revenues spent on clinical services and quality improvement, also known as the Medical Loss Ratio.[6] If an insurance company spends less than 80 percent of premium revenues on clinical services and quality (or less than 85 percent in the large group market), it is required to provide a rebate to customers. The amount of returned premium dollars returned to Texas under the Experience Rebate provision will be reported. It is expected that total cost of care (capitation payments minus experience rebate) will be less than the total cost of care that would have been incurred under the Medical Loss Ratio regulation.

   Methods. For each demonstration year, Texas proposes to calculate MLR using the formula promulgated by the National Association of Insurance Commissioners and compare any returns against those calculated using the Experience Rebate Provision. The final evaluation report will include a policy analysis comparing and contrasting the two models and any recommendations for improving upon the intended purpose of each cost mechanism.

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[6] http://www.healthcare.gov/law/index.html

Table 1. Intervention One evaluation questions including performance measures, data sources, anticipated outcomes, and deliverable timelines.

Evaluation Measure Type	Evaluation Question	Performance Measure/Indicator	Data Source	Data Periodicity	Deliverable
Process Indicators	Did expansion of STAR to the Hidalgo SDA and STAR+PLUS to the El Paso, Hidalgo, and Lubbock SDA impact access to care for the target population?	Adult access to preventive/ambulatory health services	HEDIS®	Annually	Interim and final evaluation report
		Number of STAR+PLUS members who had inpatient hospital stays per 1,000 members	Managed care and Fee-for-service Encounter data	Monthly	Quarterly and interim and final evaluation report
		Top ten procedures utilized during hospitalizations for STAR+PLUS members who had inpatient hospital stays	CAHPS©	Annually	Interim and final evaluation report
		Average number of miles from STAR+PLUS members to closest participating inpatient hospital in each new service area	STAR+PLUS member addresses obtained from enrollment database. Participating hospitals obtained from Medicaid and Managed care claims data	Annually	Interim and final evaluation report

Evaluation Measure Type	Evaluation Question	Performance Measure/Indicator	Data Source	Data Periodicity	Deliverable
Process Indicators	Has the utilization of preventative (and care coordination) of dental services for children age 20 years and younger changed as a result of the expansion?	Percent of children's Medicaid dental services members who receive at least two dental check-ups in one calendar year	Monthly Medicaid claims files*	Monthly	Quarterly and interim and final evaluation report
		Percent of children's Medicaid dental services members who receive at least one fluoride treatment or dental cleaning in one calendar year			
		Percent of children's Medicaid dental services members who receive at least one diagnostic dental service in one calendar year			
	Has the carve-in of pharmacy benefits into capitated managed care impacted access to care for the target population?	Number of members who use appropriate medications for people with asthma (according to NCQA)	HEDIS®	Annually	Interim and final evaluation report

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Evaluation Measure Type	Evaluation Question	Performance Measure/Indicator	Data Source	Data Periodicity	Deliverable
Process Indicators	Did the expansion of STAR and STAR+PLUS to the new service delivery areas impact care coordination for the target population?	Percent of STAR or STAR+PLUS members in each new service area who felt their doctor was informed about the care they received from other providers	CAHPS© survey	Annually	Interim and final evaluation report
	Did automatic re-enrollment after disenrollment for STAR, STAR+PLUS, and children's Medicaid dental services impact continuity of care for the target population?	Frequency of MCO reassignment requests	MAXIMUS, enrollment broker	For one demonstration year	Interim and final evaluation report
		Reason(s) for reassignment request			
Health Outcome Indicators	Have STAR and STAR+PLUS impacted preventable ER visits and hospitalizations over the demonstration period for the target population?	Number of preventable emergency department visits per 1,000 members	HEDIS®	Annually	Interim and final evaluation report
		Number of preventable hospital admissions per 1,000 members			
		Number of preventable hospital readmissions per 1,000 members			

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Evaluation Measure Type	Evaluation Question	Performance Measure/Indicator	Data Source	Data Periodicity	Deliverable
Health Outcome Indicators	Have dental MCOs reduced therapeutic dental care to the target population (children) over the demonstration period?	Number of members who received restorative dental services per 1,000 members	HEDIS®	Annually	Interim and final evaluation report
	Has the carve-in of pharmacy benefits into STAR and STAR+PLUS impacted the number of hospital admissions due to an acute asthmatic event?	Number of asthma hospital admissions per 100,000 members	HEDIS®	Annually	Interim and final evaluation report
Cost Outcome Indicators	What is the impact of non-behavioral health inpatient services in the STAR+PLUS program in terms of cost?	Average cost of non-behavioral hospitalizations for STAR+PLUS members	Managed care and FFS Encounter data	Annually	Interim and final evaluation report
	How does Texas' Experience Rebate compare to Medical Loss Ratio regulation as a strategy for ensuring that managed care plans spend an appropriate amount of their premium revenue on medical expenses?	Amount of premium dollars returned to HHSC under the Experience Rebate Provision	TX HHSC Managed Care Operations Finance	Annually	Interim and final evaluation report

* Medicaid monthly claims files are subject to lags in data availability. Claims for most Medicaid services are available within three months of the date of service. Performance measures will be based on the data available at the end of the quarter or year. Performance measures that include Medicaid claims data will be identified as incomplete, and will be revised in the following report.

Intervention 2: Formation of Regional Healthcare Partnership (RHP) Regions (Evaluation Goals 5 – 11)

Given the Program description of RHP formation, the evaluation will include measures of process indicators describing the formation and sustainability of RHP governance structures and operations, outcome indicators, and cost outcome indicators. Process indicators will include measures of governance, stakeholder engagement, learning collaborative participation, and identifying community needs assessment. RHP projects will be developed based on the community needs identified (Provided to HHSC on October 31, 2012). Each project (Due to HHSC on December 31, 2012) will have required deliverables from each RHP, thus allowing for standardized means of comparing projects across RHPs. Health outcome measures will include measures of clinical outcomes that are associated with process indicators. Finally, select cost outcome indicators associated with process and health outcome indicators will be examined for changes associated with process or health outcome measures.
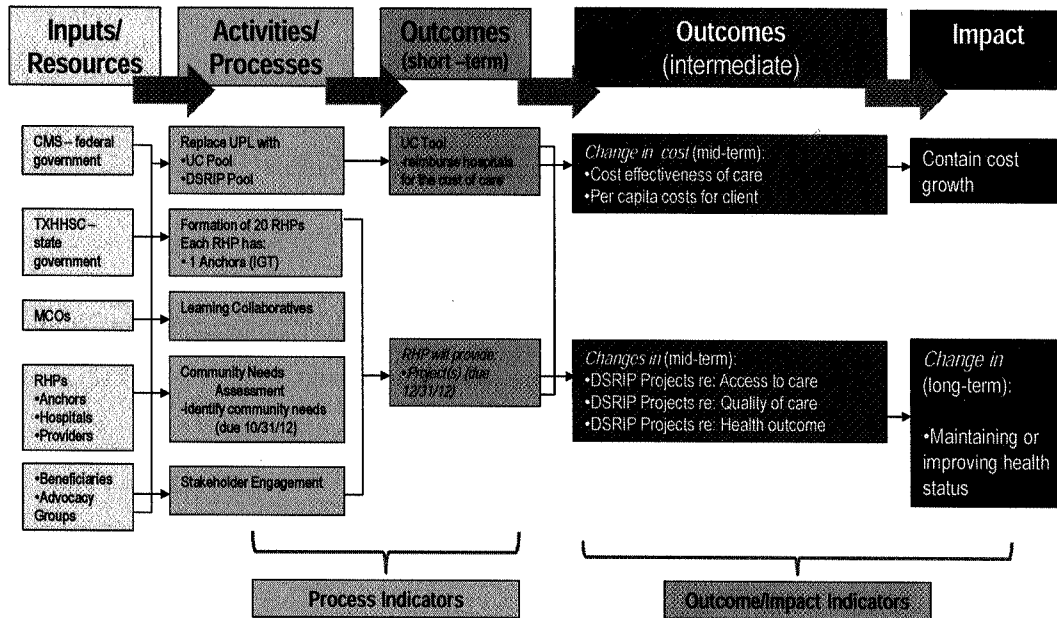
Comparative Case Study

A prospective research design will entail data collected in years 2-5 to compare performance across four to nine RHPs in the comparative case study. A mixed methods approach using quantitative, qualitative, primary, and secondary data will yield meaningful insights into factors affecting success over time. Within-case analyses will include a baseline profile of each initiative based on the Community Needs Assessment and publically available data (e.g., from Area Resource Files) on local demographics and health service provider supply; quantitative trends in utilization, cost, and quality indicators reported to HHSC; formal governance structure; repeated social network analysis; a timeline of key events; and qualitative analysis of stakeholder interviews and available documentation such as meeting minutes indicative of collaborative processes. To the extent feasible, the evaluators will also measure each initiative's implementation fidelity. Finally, between-case RHP analyses will be used to determine what patterns of resources, governance, regional power dynamics, and implementation processes distinguished more and less successful initiatives over time.

Figure 2. Logic Model for the Health System Transformation Intervention

1115 Texas Waiver Evaluation Logic Model
(Health System Transformation)

Inputs/ Resources	Activities/ Processes	Outcomes (short-term)	Outcomes (intermediate)	Impact
CMS – federal government	Replace UPL with •UC Pool •DSRIP Pool	UC Tool –reimburse hospitals for the cost of care	*Change in cost* (mid-term): •Cost effectiveness of care •Per capita costs for client	Contain cost growth
TXHHSC – state government	Formation of 20 RHPs Each RHP has: • 1 Anchors (IGT)			
MCOs	Learning Collaboratives		*Changes in* (mid-term): •DSRIP Projects re: Access to care •DSRIP Projects re: Quality of care •DSRIP Projects re: Health outcome	*Change in* (long-term):
RHPs •Anchors •Hospitals •Providers	Community Needs Assessment -identify community needs (due 10/31/12)	RHP will provide •Project(s) (due 12/31/12)		•Maintaining or improving health status
•Beneficiaries •Advocacy Groups	Stakeholder Engagement			

Process Indicators

Outcome/Impact Indicators

Data Collection

For the second intervention, Texas proposes an evaluation design that focuses on several strategies for data collection.

a. Evaluation of the extent that establishing learning collaborative strategies for success led to continuous quality improvement.

b. A longitudinal comparative case study of four to nine RHPs quantifying and conceptualizing the RHP network (i.e., actors, their interest, and especially their relations as key explanatory factors for examining the effectiveness of selected RHPs). Although network analysis is routinely cross-sectional, the Program intervention provides an opportunity to examine the creation and sustainability of a new governance structure over the demonstration period.

c. Trend comparison between selected RHPs on the extent to which the RHP impacted the quality of care, health of the population served, and/or cost of care.

Evaluation Questions

The evaluation questions are broken down into three evaluation measurement types: Continuous quality improvement measures, process indicators, and outcome indicators. Table 3 presents a summary of each evaluation measurement type including, if available, the performance measure/indicator, the data source, anticipated outcome, and deliverable timeline. Please note that much of the evaluation information for the second intervention will only be known after the submission and acceptance of the project proposals in early 2013.

Continuous Quality Improvement

The evaluation question specifically having to do with continuous quality improvement measures is described below.

1. Does the establishment of learning collaborative strategies by the RHPs lead to continuous quality improvement? (STC 68.a.v)

   o *Learning collaborative.* All RHPs are required to report their quality improvement priorities to HHSC. From these, the external evaluation team will develop a matrix showing which RHPs are addressing which priorities. For every priority addressed by two or more RHPs, external evaluators will convene an annual meeting (via face-to-face or video conference) in 2013 in which each participating RHP will outline their improvement plans, and discuss which common quality, health, and cost measures may be feasible to analyze. The external evaluators will convene quarterly conferences of all RHPs with any given focus.

   On an annual basis, the external evaluators will collect data from each RHPs learning collaborative about their common quality, health, and cost measures, and report these back to all RHPs with any given focus.

Process Indicators

The evaluation question specifically having to do with process indicators is described below.

1. How did anchors, hospitals, and providers collaborate within each RHP to support uncompensated care and delivery system reform? (STC 68.a.iv) (STC 68.a.ii)

   o *Comparative case study.* To understand how differential regional health partnership performance unfolds over time, the external evaluator will conduct a longitudinal comparative case study of four to nine RHPs employing similar project strategies that address a single goal (e.g., improving primary care access to reduce Emergency Department use). The proposed sampling strategy will ensure that RHPs include at least one predominantly rural region, one predominantly urban region, and one

mixed urban-rural (see Table 2). Data will be collected between summer 2013 and summer 2016.

Table 2. Hypothetical comparative case study sample.

		Case:								
Level of success: determined over time – hence distribution shown here is speculative	**Rurality:**	1	2	3	4	5	6	7	8	9
	Mostly successful	R			U			M		
	Partially successful		R			U			M	
	Mostly unsuccessful			R			U			M

R= predominantly rural; U=predominantly urban; M=mixed]

Possible data collected includes:
1. Each RHP's formal governance structure as reported to HHSC.
2. Social network analysis measuring the relationship of RHP stakeholders, their interest, power dynamics, and resource exchanges within each initiative dynamics and resource exchanges within each initiative.
3. Interview data on implementation processes.
4. Focus group and interview data on stakeholder perceptions, and the public health process and outcomes data each RHP reports annually to HHSC.
5. Additional data sources could be added depending on availability and consistency among selected RHPs.

Methods. Texas proposes a purposive sampling strategy for the comparative case study of RHP initiatives for four reasons: (1) we believe that the sample selection bias that is attendant to very low response rates to mail/phone surveys would outweigh the benefits of random sampling of all RHPs and/or stakeholders; (2) interviews or focus groups would yield richer information about how stakeholders experience system changes; emergent themes could be used to inform interview prompts in subsequent interviews or focus groups, as well as report back to RHPs; (3) collecting these data in the case study sites, focused on a common type of initiative across all sites, would remove potentially confounding factors associated with differences across initiative types, and hence improve comparisons and generalizations across sites; and (4) external evaluators will have established relationships with local stakeholders through the other case study data collection, which will improve participation rates and hence the representativeness of the samples.

Outcome Indicators

The evaluation question specifically having to do with outcome indicators is described below.

1. Did RHPs show an improvement in quality of care, access to care, and in health outcomes for individuals served in their catchment areas? (STC 68.a.iii)

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o **Trend comparisons.** To the extent feasible, the external evaluator will also assess progress on goals seven to nine using concurrent comparisons (e.g., difference-in-difference analyses) of trends between RHPs implementing and not implementing a few strategies with substantial health and/or cost implications. Outcome health indicators will be selected from reliable and valid measures that can be collected across multiple sites (e.g., claims and encounter data, HEDIS®, and/or CAHPS® survey questions). A concurrent comparison approach would be necessary to control for the effect of Affordable Care Act implementation in 2014.

Table 3. Intervention two evaluation questions including performance measures, data sources, anticipated outcomes, and deliverable timelines.

Evaluation Measure Type	Evaluation Question	Performance Measure/Indicator	Data Source	Data Periodicity	Deliverable
Process Indicators	How did anchors, hospitals, and providers coordinate within each RHP to oversee finance payments for uncompensated care costs and incentives for delivery system reform?	Increased communication among RHP stakeholders	RHP stakeholder focus groups, structured interviews	DY2, DY4	Interim and final evaluation report
		Increased coordination and collaboration among health service providers in each RHP	RHP stakeholder focus groups, structured interviews	DY2, DY4	Interim and final evaluation report
		Processes used for governance and decision-making within each RHP	Documentation of the processes and the coordination of those processes in each RHP plan	Annually	Interim and final evaluation report
	What communities' needs were determined from the Community Needs Assessment (due 10/31/12) and what RHP projects result from CNAs?	Summary of needs and related projects by each RHP based on CMS approved guidelines for approved data collection	Community Needs Assessment	Annually	Interim and final evaluation report

Evaluation Measure Type	Evaluation Question	Performance Measure/Indicator	Data Source	Data Periodicity	Deliverable
Health Outcome Indicators	Did RHPs show an improved quality of care for individuals served in their catchment areas?	Quality measures to be determined by metrics included in DSRIP projects submitted by each RHP.	RHP submitted project (due 12/31/12)	Annually	Interim and final evaluation report
	Did RHPs show an improvement in access to care for individuals served in their catchment areas?	Access measures to be determined by metrics included in DSRIP projects submitted by each RHP.			
	Did RHPs show improvements in health outcomes for individuals served in their catchment areas?	Health improvement measures to be determined by metrics included in DSRIP projects submitted by each RHP.	Category 3 measures	Annually	
Cost Outcome Indicators	How cost-effective was DSRIP as a program to incentivize change? How did the amount paid in incentives compare with the amount of improvement achieved?	Cost effectiveness analysis to be designed once RHP plans are turned in and compiled.	Funding benchmarks	Annually	Interim and final evaluation report

COMMUNICATION AND REPORTING

This section summarizes how information from the individual evaluation plan process and results will be used and shared. CMS and Texas agreed on several Special Terms and Conditions (STCs) related to the Program, including the following evaluation requirements (see STC 68 through STC 71).

Communication with CMS Project Officer

- Texas will submit drafts of annual and final reports to the CMS Project Officer for comments, and will submit the final evaluation report within 60 days after receipt of CMS comments.

Cooperation with CMS

- Texas will be responsible for the accuracy and completeness of the information contained in all technical documents and reports.

- Should CMS undertake an independent evaluation of any component of the Demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

Reporting

Reflecting on the purpose of Section 1115 Medicaid waivers to demonstrate innovation, Texas will report and evaluate the 1115 waiver to inform the federal government, Texas, and local governments of the progress achieved and challenges encountered as the demonstration is implemented. Please see Tables 2 and 3 for details on which performance measures will be reported quarterly, annually, by demonstration year, or at the conclusion of the demonstration.

- Texas will submit a narrative progress report to CMS 60 days following the end of each Program quarter. These quarterly reports will provide information regarding the progress of the evaluation plan and planning, evaluation activities, and interim findings. The process of regularly measuring, monitoring, and reporting to stakeholders should result in continuous performance improvement. Quarterly reporting will also provide preliminary data that will be used for the final evaluation scheduled for completion at the end of the waiver on September 30, 2016.

- The state will submit an interim evaluation report by October 1, 2015, or in conjunction with the State's application for renewal of the Demonstration, whichever is earlier. The purpose of the interim evaluation report is to present

preliminary evaluation findings, plans for completing the evaluation design, and submitting a final evaluation report by January 31, 2017. The state shall submit the final interim evaluation report within 60 days after receipt of CMS comments.

- Texas will submit a draft of the final evaluation report to CMS by January 31, 2017. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

Timeline for Implementation of the Evaluation and Reporting Deliverables

Data collection for the Program evaluation began on the first day the waiver was approved by CMS. Data will be collected throughout the waiver period. Table 4 includes the evaluation reporting timeline.

Table 4. Texas Healthcare Transformation and Quality Improvement Program Evaluation Reporting Timeline

Report	Includes Data As of the End of...	Delivery to CMS at the End of...
Year 1 Quarters 1 & 2	March 2012	May 2012
Year 1 Quarter 3	June 2012	August 2012
Year 1 Quarter 4	September 2012	November 2012
Year 2 Quarter 1	December 2012	February 2013
Year 2 Quarter 2	March 2013	May 2013
Year 2 Quarter 3	June 2013	August 2013
Year 2 Quarter 4	September 2013	November 2013
Year 3 Quarter 1	December 2013	February 2014
Year 3 Quarter 2	March 2014	May 2014
Year 3 Quarter 3	June 2014	August 2014
Year 3 Quarter 4	September 2014	November 2014
Year 4 Quarter 1	December 2014	February 2015
Year 4 Quarter 2	March 2015	May 2015
Year 4 Quarter 3	June 2015	August 2015
Interim Evaluation Report	**July 2015**	**September 2015**
Year 4 Quarter 4	September 2015	November 2015
Year 5 Quarter 1	December 2015	February 2016
Year 5 Quarter 2	March 2016	May 2016
Year 5 Quarter 3	June 2016	August 2016
Year 5 Quarter 4	September 2016	November 2016
Final Evaluation Report	**September 2016**	**January 2017**

EVALUATION MANAGEMENT

The evaluation will be conducted by internal and external evaluators. Internal evaluators will evaluate intervention one, coordinate report submissions, and provide evaluation project management. Internal and external evaluators will hold regular meetings to facilitate the evaluation of the two interventions, discuss and troubleshoot any issues relating to the implementation of the evaluation, and collaborate on results and reporting.

Internal Evaluators

The Evaluation Unit of HHSC Strategic Decision Support (SDS) will conduct the evaluation of intervention one (the Medicaid Managed Care expansion) and oversee the evaluation of intervention two (Formation of RHPs) of the Program. SDS is an independent branch of HHSC and the internal evaluation unit will leverage the expertise and capacity of evaluating statewide health and human services programs. The Evaluation Unit includes professional program evaluators with expert knowledge of the HHSC data systems used for this evaluation, and with ongoing, unlimited access to the data. The internal evaluation unit has direct access to policy experts and is informed about policy and procedure changes that may affect the evaluation.

In addition to the Evaluation Unit, SDS includes demographers who will be providing population data for the evaluation, and more than 30 analysts who work with HHSC data and policies every day. SDS is located within the HHSC Financial Services Division. Financial Services also includes the budget and accounting staff who will be contributing to the evaluation.

External Evaluators

The external evaluation of intervention two (Formation of RHPs) will be conducted by the Texas A&M School of Rural Public Health, in their Department of Health Policy and Management. HHSC has worked with Texas A&M in the past and has a long standing relationship with their research staff. Texas A&M brings a great depth of experience and knowledge of HHSC programs and services. Specifically, their research staff has substantial experience in conducting complex, large-scale, multi-site evaluations at the state and local level; local, state, and national level quantitative surveys with Medicaid/CHIP members, providers, and other key stakeholders described in the evaluation.

The external evaluation team will be led by Drs. Rebecca Wells and Monica Wendel. Dr. Wells is the incoming Department Head in the Department of Health Policy and Management. Her experience includes: (1) comparative case studies of FQHC-led networks, behavioral health care for low income families involved with child welfare, and implementation of a Medicaid medical homes model for pregnant women and children; (2) social network analyses of behavioral health-primary care integration and public mental health system responses to people in crisis; (3) longitudinal analysis of a state-wide care

coordination initiative's implementation; and (4) multiple regression analyses of how teamwork within and across safety net providers affected health care use and outcomes.

Dr. Wendel is the Assistant Dean for Community Health Systems Innovation at the School of Rural Public Health and is an assistant professor in the Department of Health Policy and Management. She has led several large-scale, multi-site complex evaluations, including the Steps to a Healthier San Antonio program (funded by the Centers for Disease Control), Legacy Partners for Healthier Communities (funded by the American Legacy Foundation), and the Minority Youth Tobacco Elimination Project (funded by the Office of Minority Health). Each of these evaluations included a multi-site, mixed methods design and entailed both process and outcome measures.