Texas Health and Human Services Commission - Center for Analytics and Decision Support Technical Response to Comments from the Centers for Medicare and Medicaid Services'

Texas Health and Human Services Commission (HHSC) - Center for Analytics and Decision Support (CADS) Summary:

Texas Health and Human Services Commission (HHSC) appreciates CMS' thorough review of the draft Final Evaluation Report for the Texas Healthcare Transformation and Quality Improvement demonstration. Texas HHSC has addressed each question, comment, and/or recommendation, and provided the location in the Final Evaluation Report where a modification may be found or rationale for why a change was not made. As per STC section 75(c), the Final Evaluation Report focuses on addressing requirements specified in the CMS-approved evaluation plan.

Centers for Medicare and Medicaid Services (CMS) Texas Draft Final Evaluation Comments 3/8/2017

Executive Summary:

CMS appreciates the opportunity to review the draft Final Evaluation Report for the Texas Healthcare Transformation and Quality Improvement demonstration. We have developed a list of questions, comments, and recommendations for strengthening the report. The comments and questions are categorized into sections as follows: DSRIP, Stakeholder Analysis, Managed Care, and Collaboration. Our comments include recommendations for additional statistical analysis to further the robustness of the evaluation, and providing caveats where necessary about the statistical strength of the evaluation. CMS recognizes that a number of these areas cannot be addressed now, given the point in time, so we ask the state to indicate explicitly where modifications cannot be made and its reasoning.

We will not be including commentary on the UC section, as it is not yet complete. We ask the state to revise the UC section, once it receives 2017 data, and submit it to CMS for review.

1. Delivery System Reform Incentive Program (DSRIP)

Recommendations for strengthening the final evaluation report: DSRIP Section

Additional contextual information

1. The Texas DSRIP demonstration is large and the CN projects assessed in the evaluation represent a small component of the overall demonstration. Given that the CN projects seek to decrease the use of ED services, we recommend the final report provide contextual information on trends in ED visit rates at either the state or RHP level. Ideally, the trend information would provide ED visit rates for periods before and after the launch of the RHPs to identify pre-DSRIP trends in ED visit rates. For state level rates, Medicaid claims and encounter data would be one possible data source, although the rates would not capture ED visit rates among the uninsured. The performance measurement data reported by the RHPs to the state may be an alternative data source. These data would not provide information about pre-DSRIP trends, but presumably they can provide information on how ED visit rates are changing as the DSRIP demonstration matures. Including some type of high-level data on ED utilization rates would also help the final evaluation report better address STC 73(c) and the request to include aggregate program level analyses to the extent feasible.

HHSC RESPONSE:

- Text in the background section has been updated to include recent state-level ED utilization as published in a recent report:
    - .Hing E, Rui P. Emergency department use in the country's five most populous states and the total United States, 2012. NCHS data brief, no 252.Hyattsville, MD: National Center for Health Statistics. 2016.
- DSRIP was not limited to Medicaid clients, so using Medicaid claims and encounters data would not fully represent the DSRIP population.
- Additionally, there are other issues in attempting to address this comment. Texas emergency department data are available through

the Center for Health Statistics - Texas Health Care Information Collections (THCIC) program. However, THCIC started to collect outpatient emergency department data in January 2015, too late for inclusion in the Demonstration evaluation (data can be selected from the Public Use Data File, but the first report based on these data is due out this year). The inpatient public use data file contains information regarding ED visits for those individuals who were admitted to the hospital through the ED, but only 10% of ED visits in Texas result in admission to the same hospital (Hing and Rui, 2016); so any analysis of these data would likely not be representative of all ED visits or individuals seen in the ED in Texas.

- Updates found:
    - Appendix E: Background, Health Care Delivery Context (pg. 18)

2. The description of the 10 case study sampling areas is helpful, but readers would benefit from having additional information on how the 10 DSRIP CN projects and the 10 comparison sites are distributed across the 10 sampling areas. Did the evaluators select one DSRIP CN project and one comparison site from each of the 10 sampling areas or are some DSRIP CN projects (or comparison sites) from the same sampling area? In addition, the report notes that patients from the comparison sites are frequent visitors to EDs, how do the patients at DSRIP CN projects compare on this dimension, were they also frequent ED users? This type of information would help the reader understand how the comparison sites and patients from these sites compare to the DSRIP CN projects and their patients.

HHSC RESPONSE:

- The text was updated to include additional information regarding the ways in which DSRIP cases were matched with comparison sites in the same study area (at least in most cases).
- The text was updated to more clearly compare the identification of frequent ED users at both case and comparison sites.
- Updates found:
    - Appendix E: Evaluation Design, Sample and Units of Analysis (pg. 21)
    - Appendix E: Evaluation Design, Data Collection, Patients and Patient Family Members (pg. 30)

3. The discussion of the qualitative information gathered during site visits and key informant interviews did not provide much information on how DSRIP CN projects have been evolving over time as they become more mature programs or how DSRIP CN projects compare to what is happening at the comparison sites. The report would be greatly enhanced if the evaluators could provide more information about the evolution of these programs or provide a comparative analysis between DSRIP CN and comparison sites. For example, in the interim evaluation report one theme from the initial site visits was the role of electronic medical records (EMRs) and how they could help with communication across providers. A better window into the DSRIP CN projects would discuss how this theme has evolved, such as whether and how the use of EMRs has grown over time, either in the identification of patients who could benefit from CN services or to facilitate communication across providers. A key question is whether any of the sampled DSRIP CN projects have implemented EMRs that partner organizations can access.

HHSC RESPONSE:

- The text has been updated to further communicate findings based on interviews with key informants, front-line staff, and patients to reflect stakeholder experience with system change.
- Important to consider - as noted in Key Informant Characteristics, Appendix E, pg. 42, "the relatively low continuity in whom the team interviewed over time reflected frequently changing roles within DSRIP projects as well as some turnover." As a result, analysis of interview data often provided different key informant perspectives over time rather than comparisons over time in how the same key informants experienced system change.
- Updates found under each related section in Appendix E, including:
    - Example: Results, Defining DSRIP Care Navigation (pgs. 33) – quote from a key informant describing how projects evolved over time.
    - Example: Results, Context, Rurality, Funding and Staffing Shortages (pg. 37) – some rural projects had to reduce the scope of their projects due to staffing shortages

4. Were the 10 CN sites involved in any collaborative learning or rapid-cycle evaluation?

HHSC RESPONSE:

- Yes, representatives of the CN sites were involved in learning collaboratives as was required based on their RHP tier. While the learning collaboratives were not necessarily focused on CN, key informant comments were positive in that they were able to share lessons learned and learn from others as everyone gained more experience with DSRIP over time. The learning collaboratives were just getting started at the time of the interviews, so while key informants seemed to be participating and growing from the experience, more information and specific details would likely be revealed over time, i.e., later than when the interviews took place.
- Rapid-cycle evaluation was not asked about in the interviews with CN key informants, but in an analysis of regional healthcare partnership (RHP) learning collaborative plans and activities, the RHP plans were reviewed. This document review indicated that "All RHPs indicated plans to use the Institute for Healthcare Improvement Breakthrough Series Model with Plan-DO-Study-Act or Plan-Do-Check-Act cycles for Continuous Quality Improvement (CQI).
    - Previously included text found:
        - Appendix D: Results, Review of RHP Learning Collaborative Plans and Activities (pg. 39)

Additional information about the patient-level outcome analyses

5. We are concerned that the analyses of patient-level outcomes based on survey data are underpowered. The sample sizes may be adequate for the unadjusted comparisons of means and frequencies, but we believe they may be inadequate when used in a regression framework. We recommend that the evaluators seek support from a statistician to develop and include post hoc power calculations in the final version of the final evaluation report. The purpose of these calculations would be to provide calculations of the minimum effect size that this study can detect given the sample sizes obtained. These calculations should be adjusted for the regression modeling used in the analysis.

HHSC RESPONSE:

- The text has been updated in various places to describe the power analysis conducted, note models that were determined to be underpowered, and the limitations section has been updated to acknowledge this issue as well.
- Updates found:
    - Appendix E: Evaluation Design, Quantitative Analysis (pg. 31)
    - Appendix E: Results, Outcomes, DSRIP Care Navigation as a Predictor of Health Care Quality (pgs. 68, 69)
    - Appendix E: Conclusions, Strengths and Limitations (pgs. 80) (already included from draft Final Evaluation Report)

6. We believe the final report should include more information to help the reader assess the representativeness of the sample of patients who responded to the phone survey. The study's sampling frame included only 1,471 patients, which seems small and the report should provide more justification for their approach to developing the sampling frame for the survey. Readers know that the evaluators did not get rosters from all sites, which may bias the results, depending on which sites were not included. For example, the report indicates that rural patients are underrepresented in the study sample because they did not get any responses from two rural sites. In addition, the final evaluation report indicates that the patient phone survey obtained a 30 percent response rate. This is a low response rate and may have biased the sample in some way as well. The report should provide information on how the sample of survey respondents compares to either everyone in all the sampling frames they received from the 15 sites or to some other data source that describes the characteristic of the patients served in the EDs from all study sites (or at least are served by the DSRIP CN projects). Readers need to understand any biases that might be in the survey data to help them interpret study results.

HHSC RESPONSE:

- The text has been updated to address the issue of non-response bias potentially influencing survey results.

- Updates found:
    - Appendix E, Results, Context, CN Project and Comparison Sites, Patient Characteristics (p. 44)

7. We also recommend that the final evaluation report provide an explanation for why the claims analysis presented in the interim evaluation was not repeated with more recent years of data. That analysis from the interim report was informative and repeating it may have provided some insight into how ED utilization rates were changing over time. Helping readers and stakeholders understand the challenges of this type of analysis and its utility would be helpful.

HHSC RESPONSE:

- The Approved Evaluation Plan specified 'health improvement measures' were 'to be determined.' The analysis conducted for the interim report described Medicaid-only clients. Of these clients, it is unknown how many received DSRIP care navigation services. (Claims data do not indicate DSRIP care navigation and DSRIP data do not include Medicaid ID numbers so there was no way to determine DSRIP participation among these Medicaid clients.) Therefore, this analysis was not included in the final report as it was determined that these data were not necessarily reflective of, or generalizable to, the broader DSRIP care navigation population. In the Final Evaluation Report, health improvement was reported through an analysis of the number and length of stay of hospitalizations among case and comparison sites.

8. Since care coordination (and theoretically navigation) is inherent to primary care practices, and discharge planning is inherent to hospitals, it would be interesting to know what the comparison groups are/were doing that did not entail "projects," and what the DSRIP project providers were doing in this area before DSRIP. In other words, were these providers performing any "inherent" functions or did they scrap what they were doing and start over via DSRIP to no additional benefit?

HHSC RESPONSE:

- Key informants at the comparison sites did indeed often describe other efforts to provide disease management and care coordination for patients with medically complex needs.
- Key informants and front line staff at the DSRIP care navigation sites sometimes characterized DSRIP care navigation as entirely new, and sometimes as a significantly different version of prior services. For instance, a care navigator at one large urban hospital noted that she was initially frequently explaining to patients and clinicians how her new role differed from her prior role as a case manager. In general, DSRIP staff characterized care navigation as differing from case management in that care navigation was more holistic and potentially longer lasting.

9. On page 5, the state notes "additional quantitative results indicate specific navigational processes and contextual factors that were associated with better outcomes." Please indicate these specifically; we are not sure that there is enough in the later text to substantiate improved quality and health outcomes.

HHSC RESPONSE:

- Text has been updated to further clarify specific navigational processes and contextual factors that were associated with better outcomes.
- Updates and clarifications found:
    - Appendix E: Results, Processes, Models Associated with Improved Health Care Quality
        - Care navigation processes that predicted improved health care quality:
            - Patients who reported knowing what their medications did were more likely to report having enough information about treatment options available. (Table 21)
            - Patients who reported using a personal health record to help track and manage their health care had a greater probability of reporting that they had information about treatment options and health education available. (Table 21)

        - Patients who reported having enough information to manage their health conditions had a greater probability of reporting that they had information about treatment options, their rights as a patient, and about their right to refuse a specific type of medication, test, or treatment. (Table 21)
    - Appendix E: Results, Context, Organizational and Local Contexts
        - Contexts that predicted improved health care quality:
            - Patients in sites where care navigators had high role clarity had a greater probability of reporting that they had information about the different kinds of education or treatment that were available. (Table 17)
            - Patients who reported using a personal health record perceived that they had greater access to health care. (Table 18)
    - Appendix E: Results, Context, Organizational and Local Contexts, Contextual Factors as Predictors of Health
        - Contexts that predicted improved health:
            - Patients in sites where care navigators had high role clarity on average reported better mental health. (Table 19)
    - Appendix E: Results, Context, Organizational and Local Contexts, Contextual Factors as Predictors of Costs
        - Contexts that predicted improved costs of care :
            - Patients who used a personal health record to track and manage their health care were less likely to have visited the ED in the previous month. (Table 20)

10. CMS suggests that the state include a section including descriptive statistics for aggregate project achievement, to further convey that the DSRIP was not limited to care navigation interventions.

HHSC RESPONSE:

- To convey to the reader that DSRIP was not limited to care navigation interventions, the text has been updated to include a table that displays all DSRIP projects by primary project type and RHP.

- To report aggregate project achievement, the text was updated to include a table that displays the aggregate quantifiable patient impact (QPI) of DSRIP projects from demonstration year (DY) 3 through DY5. QPI was measured as either the number of individuals served or encounters provided through a DSRIP project – this is a count of individuals and encounters beyond baseline, i.e., occurred specifically due to DSRIP funding.
- Updates found:
    - Appendix E: Background, DSRIP Projects Statewide (pgs. 13-15, tables 3-4)

11. Category 3 measure could provide an additional means to evaluate the effectiveness of DSRIP. How have associated Category 3 measures performed for the 10 CN projects? Have they been achieving their performance targets? A brief presentation on this would provide additional context.

HHSC RESPONSE:

- The text has been updated to include a table to display the aggregate quantifiable patient impact (QPI) achievement among the 10 CN case sites. Category 3 percent earned was not included in an effort to maintain confidentiality for the CN case sites. For interpretation of the results to be meaningful, some individual detail would need to be revealed and thus compromise the confidentiality of the case sites.
- Updates found:
    - Appendix E: Evaluation Design, Conceptual Framework and Measures, Outcomes, Overall DSRIP Quantifiable Patient Impact (pg. 24)
    - Appendix E: Results, Care Navigation – Quantifiable Patient Impact of Case Sites (pg. 45-46, Table 16)

12. Can anything be learned about the relative effectiveness of different types of Category 1 and 2 projects using the results from their associated Category 3 measures?

HHSC RESPONSE:

- While this request is beyond the scope of the Approved Evaluation Plan, in an effort to communicate more about DSRIP results overall,

the Category 3 percent earned was calculated for each primary project type for DY3 through DY5. Category 3 percent earned was calculated as: [(approved amount) / (project value) * 100]. The *project value* was the project's valuation, or maximum amount the project could earn, as determined at the time the project was approved. The *approved amount* is the payment amount approved by HHSC, based on metric and milestone reporting. Since performing providers were paid based on their achievement of metrics and milestones, the Category 3 percent earned provides a proxy measure to the overall success of the project in terms of meeting Category 3 metrics and milestones.

- Updates found:
    - Appendix E. Background, DSRIP Projects Statewide (pgs. 16-17, Table 5)

2. Stakeholder Analysis

Recommendations for strengthening the final evaluation report: Stakeholder Section

We view the stakeholder perceptions and recommendations and LC analyses as being responsive to the evaluation requirements and planned RQs. However, we believe the evaluator could improve the report through a number of additions or clarifications.

1. We think the overall conclusions in the executive summary would be stronger if it reflected a closer integration of the different analyses conducted by the evaluator and, at a minimum, highlighted findings related to the MMC expansion and UC pool program, in addition to DSRIP (which is the current focus of the summary and conclusions).

HHSC RESPONSE:

- The executive summary has been updated regarding MMC and UC to balance the DSRIP focus. Additionally, the findings have been restructured to clarify that MMC, UC, and DSRIP have all been addressed.
- Updates found:

- Executive Summary and Overview, Evaluation Goals 10-11, Key Findings and Conclusions (pgs. 22-24)

2. We view the lack of information about RHP governance models and fund flow to be critical information gaps. To the extent possible, the report would be more useful if it provided more information about the types of governance models used, the perceived benefits and drawbacks of the various models, and the processes RHPs used to manage fund flow.

HHSC RESPONSE:

- Although HHSC provided guidance on RHP formation requirements (STCs, Attachment J: Program Funding and Mechanics Protocol), the RHPs determined how formally or informally their governance structure would operate. There was no requirement to follow a specific governance model.
- The text has been updated to include information regarding governance models, what kinds of factors may have affected them, how they may have affected stakeholder perceptions, as well as fund flow in the RHPs**.**
- Updates found:
  - Appendix D: Background for Evaluation Goals 10 and 11 (pg. 6-7)
  - Appendix D: Results, Module 1: Members' Experience with their RHP, Role and Influence of RHP Members (pg. 17)
  - Appendix D: Results, Module 3: Perspective from Non-Participating Organizations, Challenges (pg. 33-34).

3. Given the low response rate of only 8 percent overall, the report needs to help the reader understand any biases introduced as a result. The inclusion of a profile of survey non-respondents, including nature of their affiliation with RHPs and the types of organization represented, and how they compare to survey respondents would help readers and stakeholders understand the representativeness of the survey sample.

HHSC RESPONSE:

- The text was updated to be more specific in the narrative about why and from where the sample was obtained. Evaluators cannot discuss

non-respondents because they don't have any information about them other than email addresses.
- Updates found:
    - Executive Summary and Overview, Evaluation Goals 10-11, Evaluation Design (pg. 21)
    - Appendix D: Evaluation Design, Sample (pg. 10)

4. The report would be stronger if it included a more detailed discussion of the sampling approach used for the survey of stakeholders. A sample identified via RHP plans and HHSC email contacts may potentially bias the sample, and the resulting sample may underrepresent stakeholders who were not directly involved in the demonstration but who were potentially affected by the demonstration, such as patient and consumer groups.

HHSC RESPONSE:
- Text has been updated to include more specific information in the narrative regarding the sampling frame and strengths and weaknesses of this approach.
- Updates found:
    - See Appendix D: Evaluation Design, Sample (pg. 10)

5. To help the readers better distinguish between common and less common issues, it would be helpful if the evaluation report identified which strengths, weaknesses, and recommendations identified through the survey analysis were named by a majority of respondents.

HHSC RESPONSE:
- Text has been updated throughout to more explicitly state that the strengths, weaknesses, and recommendations reported are those most commonly reported by stakeholders who responded to the survey; and that the recommendations are based on the qualitative analysis conducted.
- Updates found:
    - Executive Summary and Overview (throughout)
    - Appendix D (throughout)
        - Examples include:

- Executive Summary and Overview, Stakeholders' Perceptions and Recommendations (pg. 5)
- Appendix D: Results, Module 2: Stakeholders' Perceptions of the Demonstration, Perceptions of Uncompensated Care (UC) Program, Strengths of Uncompensated Care Program (pg. 26)

6. The final report would be more complete if the evaluation report included a discussion of all the perceived disadvantages of the RHP structure and leadership that were raised by survey respondents. In addition, additional analyses to identify any patterns for respondents with lower levels of satisfaction would enrich the report and provide a more balanced analysis.

HHSC RESPONSE:

- Text has been updated to include clarification regarding the small cell count in looking at those who were dissatisfied and the inability to draw conclusions or generalize about them. There was an 8% response rate to the survey and less than 5% dissatisfaction rate, so 5% of the 8% of respondents were dissatisfied. The results were in some cases as low as one to two dissatisfied respondents in an RHP. This low cell count makes the numbers sensitive to outliers when conducting analysis at the RHP level.
- Updates found:
    - Appendix D: Results, Module 1: Members' Experience with their RHP, Anchor Institution Effectiveness (pg. 16-17)

7. Given the importance of the finding that less money may be allocated to providers under the UC pool program compared to the UPL program, additional research or discussion on why this might be occurring would be helpful to understanding the implications of the UC pool.

HHSC RESPONSE:

- The text has been updated to include additional information regarding the differences between UC and UPL; as well as how the introduction of DSRIP provided another venue that required intergovernmental transfers (IGT), but that was more concrete in terms of outcomes

(thus making UC less attractive to smaller IGT entities like cities/counties in suburban/rural areas).
- Due to the timeframe allotted for responses to these comments and the scope of the Approved Evaluation Plan, additional research on this topic was not conducted.
- Updates found:
    - Appendix D: Results, Module 2: Stakeholders' Perceptions of the Demonstration, Perceptions of the Uncompensated Care (UC) Program, Recommendations to Improve Uncompensated Care (pg. 27-28)

8. The survey analysis revealed that political circumstances influenced provider participation. It would be helpful if the evaluator could provide any additional data on the implications of these political circumstances for provider participation.

HHSC RESPONSE:
- The text has been updated to include additional information and examples to illustrate the implications of the political circumstances that influenced provider participation.
- Due to the timeframe allotted for responses to these comments and the scope of the Approved Evaluation Plan, additional data were not collected to further analyze such political circumstances.
- Updates found:
    - Executive Summary and Overview, Stakeholders' Perceptions and Recommendations, Background for Evaluation Goals 10 and 11 (pg. 20)
    - Appendix D: Background for Evaluation Goals 10 and 11 (pg. 6-7)
    - Appendix D: Results, Module 3: Perspectives from Non-Participating Organizations, Opportunities and Challenges of the Demonstration, Challenges (pg. 33-35)

3. Managed Care

Recommendations for strengthening the final evaluation report: Managed Care section

We have several recommendations for how the final evaluation report could be strengthened. One set relates to providing more contextual information about MMC policies that may also be affecting the outcomes measured and other data that might be included to provide a broader perspective on the MMC program. A second set of recommendations relate to aspects of the methodology used.

Additional contextual information.

1. The discussion of results could be enhanced if the report included more information about relevant MMC polices. Examples include the discussion of the STAR+PLUS care coordination measure for ambulatory visits for existing patients. Most managed care programs, particularly those that include LTSS, have an "any willing provider" provision, at least during the initial years of the program, which allows enrollees to continue seeing their previous providers to help maintain the continuity of care for members while they transition from the FFS to managed care payment systems. If the Texas MMC program included this type of provision during the initial years of the expansion, a discussion of how it might affect the volume of ambulatory visits among existing patients would help the reader interpret the findings. Other examples include:
    a. which children received dental care through the MMC system before 2012 and which children received dental care through the FFS system in 2012 and later to help readers interpret the FFS and MMC differences reported in Figure 10;
    b. whether and how children of different race/ethnicity characteristics cluster either across rural and urban areas of the state or across the different regions to help readers interpret the race/ethnicity differences in dental care;
    c. whether Texas implemented any changes in prescribing guidelines at the same time of the expansions to help readers assess the changes in prescription medication outcomes;

d. a discussion of the reporting burden of the Experience Rebate provisions on the MCOs given that most health plans must now report the Medical Loss Ratio for their other lines of business, particularly given that for 8 of the 18 MCOs assessed, there were no or very minor differences between the amounts for the Experience Rebate and Medical Loss Ratio.

HHSC RESPONSE:

- Descriptive information regarding specific programs has been added to provide more context to assist readers interpret results.
- Updates and previously included text:
  - Dental program information
    - Appendix B: Background for Evaluation Goals 1-4, Children's Medicaid Dental Program (pg. 9)
    - Appendix B: Results, Evaluation Goal 1: Access to Care, Access to Utilization of Dental Benefits (pg. 37)
  - Dental results and race/ethic distribution of children throughout Texas
    - Appendix B: Conclusions; Summary of Results, Access and Utilization of Dental Benefits (pg. 68)
    - Even though some urban/rural spatial clustering of race/ethnicity in Texas exists, HHSC thinks a more appropriate measure of dental access is DMO provider network analyses.
  - There were no significant changes in prescribing guidelines that would impact Medicaid clients;
    - Appendix B: Conclusions, Strengths and Limitations (pg. 72)
  - Experience Rebate versus Medical Loss Ratio (MLR):
    - Appendix B: Results, Evaluation Goal 4: Efficiency Improvements and Costs (pg. 60-65)
    - There is little or no "reporting" required that is due to the Experience Rebate. The MCOs simply have to calculate what amount is due, which is generally once or twice a year. HHSC provides a fairly short and simple tool that MCOs use to do this calculation, and the handful of numbers that are input into the tool are readily available from other reporting that would be required whether or not

there was an Experience Rebate. So there is very little administrative burden involved. HHSC hopes to develop an MLR calculation tool that will make the MLR calculation almost as easy.

- The Experience Rebate is a long-proven and very valuable process, with little or no associated administrative burden. It has returned well over a billion dollars back, of which half or so has been remitted to CMS. It has served as a critical safety mechanism in protecting the taxpayers' interests, including for new program roll-outs and new MCOs.
- HHSC has used the Experience Rebate for over a decade and has found it to be a very useful tool contributing to the success of MMC in Texas.

2. **Consumer perspective.** The evaluation of the MMC program presented in the final evaluation plan does not include any information about the perspective of members, their families, or consumer advocacy groups. At a minimum, if the evaluators could bring in information from the CAHPS® data reported by the MCOs, this additional information would help readers understand how consumers view the MCOs contracting with Texas. It would be particularly useful to compare results from the most recent CAHPS® surveys of managed care members in the expansion regions to the statewide averages. Even if the results do not compare pre/post the expansions, this type of comparison would help readers understand whether members in the expansion regions are more or less satisfied with their care than those in the rest of the state.

HHSC RESPONSE:

- CAHPS® survey results for two questions have been added to the report.
  - *Percent of clients who felt their personal doctor **always** or **usually** seemed informed and up-to-date about the care they got from these [other] doctors or other health providers.*
  - *Percent of clients who rated their health plan as 9 or 10 on a scale of 0 (worst) to 10 (best)*
  - IT IS IMPORTANT TO NOTE that while these results are included for the pre- and post-expansion periods, these results are based

on a statewide sample of the MMC population at that point in time. That is, the MMC expansion areas are not actually included in the Pre-Demonstration years because MMC was not there at that time. Additionally, given that these are statewide samples, results cannot be stratified by MMC service delivery area, except in more recent years when the Medicaid Rural Service Areas were purposely over-sampled to allow for this stratification of results.

- Updates found:
  - Appendix B: Results, Evaluation Goal 2: Care Coordination
    - Client Perception of how Informed Providers are About Care (pgs. 44-46, tables 17-19)
  - Appendix B: Results, Evaluation Goal 3: Quality of Care
    - Client Satisfaction with Health Plan (pgs. 50, 58-59, tables 35-37)

3. **The definitions of the post-expansion periods.** The years and regions used to construct post-expansion measures are not always clearly defined. Providing more clarity is important because the expansion of STAR and STAR+PLUS occurred in different areas of the state at different times for different populations. For example, the evaluation examined the rate of inpatient hospitalizations "over the demonstration period" for STAR+PLUS members in El Paso, Hidalgo, Lubbock, and MRSA SDAs (the expansion areas). But the expansion to these areas occurred at different times: 2012 in El Paso, Hidalgo, and Lubbock, but 2014 in the MRSAs. The difference in the post-demonstration period means that, in some cases, the post-demonstration period is three years and in other cases one year. If the evaluation did not control for the staggered implementation of the expansions, then it raises questions about the influence of other service delivery changes or population characteristics that might account for some the effects detected.

HHSC RESPONSE:

- Text was updated to more clearly explain the pre- and post-expansion periods, particularly for STAR+PLUS as there were two expansions of this MMC program
- Updates found:
  - Appendix B: Evaluation Design, Methods (pg. 19)

- Appendix B: Evaluation Design, Methods, STAR+PLUS Staggered Implementation (pg. 28)

4. **Sample sizes.** The final evaluation report does not include any information on the number of Medicaid beneficiaries included in the analyses, either overall or by year. Although we believe many of the analyses most likely have adequate sample sizes, some may rely on either small samples or a very small proportion of the population affected by the changes in the MMC program. The analyses of the STAR+PLUS expansion, which is done at the SDA-level, is an example where readers would benefit from understanding the number of members included in the analysis disaggregated by SDA. In addition, the analyses based on members with SPMI are of particular concern, given that the analyses rely on assessing one urban area compared to the entire state. In both examples, the samples are also restricted to Medicaid-only members.

HHSC RESPONSE:

- The MMC evaluation utilized eligible program populations, not samples. There are tables in Appendix B (Tables 42-51) providing demographic information for the selected populations for STAR/STAR+PLUS programs, for each SDA by Federal Fiscal Year.
- Additionally, the text has been updated throughout the Results section to include the size of the population (N) included in each analysis as certain measures have inclusion/exclusion criteria that limit the individuals that may be utilized in their calculation. In these cases, the N provided represents the entire eligible population for that measure (i.e., STAR members with asthma), not a sample.
- Updates found:
  - Appendix B: Results (throughout)

5. **Members dually eligible for Medicare and Medicaid.** We understand the challenges of evaluating members dually eligible for Medicare and Medicaid and why Medicare data are not available. However, the implications of excluding the dually eligible should be discussed, particularly for the outcomes of the STAR+PLUS expansion. At a minimum, the evaluation report should note the percentage of STAR and STAR+PLUS members who are dually eligible and excluded from the analyses so the reader can better understand how the lack of information

on this segment of the MMC members is likely to affect the overall results. [1]

HHSC RESPONSE:

- Text has been updated to more fully explain and justify why dual-eligible individuals were excluded from the STAR+PLUS analyses.
- Updates found:
    - Appendix B: Evaluation Design, Methods, STAR+PLUS Program (footnote added, pg. 23)

6. **Effect sizes.** The final evaluation report would also be stronger if it discussed effect sizes more for statistically significant findings. In some cases, the effect size is small and may not have much meaning from a clinical and/or policy perspective.

HHSC RESPONSE:

- Text has been updated to discuss the interpretation of small but statistically significant effect sizes. HHSC acknowledges that such effect sizes may not represent meaningful change at the program level.
- Updates found:
    - Appendix B: Conclusions, Ongoing Challenges (pg. 72)
    - Appendix B: Conclusions, Strengths and Limitations (pg. 72)

7. **Data quality.** The final evaluation report does not address the quality of encounter data used in the evaluation. Previous analyses have found encounter data reported to CMS through the national Medicaid Statistical Information System (MSIS) of insufficient quality for research on inpatient hospital services for adults, people with disabilities, and people above age 65, and not available for prescription drugs used by all populations. In addition, communications with the state as part of the national evaluation of MLTSS programs indicated that the poor quality of the encounter records in MSIS is consistent with the quality of encounter

[1] According to 2014 CMS' Medicaid Managed Care Enrollment data, there were 230,052 dual-eligibles enrolled in Medicaid managed care with or without LTSS (including STAR and STAR+PLUS) compared to 413,414 STAR+PLUS enrollees overall.

data collected and maintained by the state. It is unclear whether the researchers obtained sufficiently high quality data to calculate accurate measures or whether they used other techniques (for example, imputation or dropping populations or services for which data were incomplete) to calculate measures. Readers need to understand the data quality issues that are likely to affect the research and estimated effects of the expansions and benefit changes.

HHSC RESPONSE:

- Text has been updated to further discuss data quality.
- Updates and previously included text found:
    - Appendix B: Evaluation Design, Methods, Data (pg. 24)
    - Appendix B: Conclusions, Strengths and Limitations (pg. 72)

Executive Summary and Overview pg. 1: The State of Texas (the State) 1115(a) Demonstration Waiver Final Evaluation Report (the report) asserts the managed care delivery model emphasized improvements in access, care coordination, and cost, while results were mixed for healthcare quality. In addition, connections among providers within Regional Healthcare Partnerships (RHPs) decreased in the years following the implementation of the Demonstration. Please elaborate how the State was able to improve access to care and care coordination since RHP providers' relationships decline over the Demonstration period. The report also proclaimed there was decline in healthcare quality. Please clarify if there is a correlation between healthcare quality and the decline within the RHPs and providers relationships during the course of the Demonstration.

HHSC RESPONSE:

- For evaluation purposes, the Demonstration was divided into two interventions – the expansion of Medicaid managed care (MMC) and DSRIP/UC. The conceptualization and operationalization of 'providers' is different between the two interventions; therefore, the association cannot be made given the data available. For example, MMC providers are not necessarily DSRIP providers and vice versa, and relationships among providers in RHPs were not limited to MMC providers.

8. **Effects of Medicaid Managed Care (MMC) Expansion pg. 2 and Conclusion pg. 10**: Please explain why the State experienced dental utilization decreases by sex and age since the MMC expansion implementation. More specifically, the report on pg. 35 notes a decline in dental benefits for Medicaid-enrolled clients under age 21. Please describe the cause(s) for the utilization decline. Does this mean the decline in dental utilization is an access issue? In your response, describe programmatic changes implemented to address this issue.

HHSC RESPONSE:

- The current evaluation investigated the trend in dental utilization, but not the underlying causes of any changes in utilization; therefore, we cannot determine if changes in utilization are appropriate or not.
- In an effort to further clarify this issue and provide context for interpretation of the trend results, the text was updated to reflect the fact that the shift from FFS to MMC for dental services was in an effort to encourage efficient and appropriate utilization and that there were no programmatic changes to the dental benefits package.
- The conclusion statement related to dental utilization was updated to recognize that the decreased utilization may be due to more efficient delivery of dental services under the MMC model.
- Updates found:
    - Appendix B: Results, Evaluation Goal 1: Access to Care, Access and Utilization of Dental Benefits (pg. 37)
    - Appendix B: Conclusions, Summary of Results, Evaluation Goal 1: Access to Care, Access and Utilization of Dental Benefits (pg. 67)

9. **Effects of Medicaid Managed Care Expansion pg.3:** We note the report indicates the State intends to evaluate further this MCC expansion, specifically for clients utilizing long-term services and supports (LTSS). Does this mean the report does not have an adequate evaluation of access, quality of care and care coordination for the LTSS population? In your response, please elaborate how the State intends to evaluate access, care coordination, cost and quality of care for the LTSS population.

HHSC RESPONSE:

- LTSS clients were included in the evaluation to the extent they were eligible for the STAR+PLUS program. While these LTSS clients were included in the overall STAR+PLUS evaluation, evaluation of specific LTSS services under each healthcare delivery model were not statistically tested. The statement on page 3 referenced the need to include analyses of LTSS subpopulations in any future evaluation plans that may be drafted.

10. **Summary pg. 5:** The report notes during the initial implementation of the Demonstration there were several issues that cause disruption to many participating providers especially for those in rural areas. Issues consisted of the level of organizational changes required to implement DSRIP projects, uncertainties about DSRIP reporting requirements and payment. Please describe how the State ensures beneficiaries continue to have access to quality care. In addition, elaborate if there were any provider network adequacy issues and describe resolutions implemented.

HHSC RESPONSE:

- CMS redacted this question on 3/23/17 per an email from Eli Greenfield.

11. **Conclusions pg. 10, Pharmacy Carve-In - asthma hospitalizations pg. 44 and Pharmacy Carve-In - severe persistent mental illness (SPMI) Hospitalizations pg. 45**: The report suggest for STAR population there was an increase in SPMI hospitalizations and while for STAR PLUS population, an increase in asthma hospitalizations. In your response, please address the basis for increase hospitalizations. Also, please describe the State's coordination of care improvement activities.

HHSC RESPONSE:

- It is beyond the scope of the evaluation to address this comment. The evaluation was designed to identify if there was a change in hospitalizations among the asthma and SPMI populations pre- and post- MMC expansion. These data do not, however, allow us to

investigate underlying causes beyond the carve-in of pharmacy benefits into Medicaid managed care.

12. **Conclusions: The Demonstration Program Offered Opportunities and Challenges for Local Providers and Communities pg. 20**: The report notes stakeholders identified several areas of opportunities to address timing of implementation, the changing rules and expectations, the exclusion of certain types of providers, lack of infrastructure at multiple levels, the broad scope of Demonstration activities, etc. Please describe programmatic changes to address these issues.

HHSC RESPONSE:

- The DSRIP program continued to evolve upon implementation of the Demonstration. In response to these challenges, HHSC was proactive in providing prompt and transparent communication with stakeholders regarding continued development of and revisions to the DSRIP portion of the Demonstration. For example, HHSC provided:
  - biweekly Anchor calls (early in the Demonstration these calls were held weekly at the request of the Anchors) to communicate information to and solicit feedback from RHP Anchors;
  - technical assistance to performing providers;
  - webinars specific to current events (i.e., reporting requirements, responding to feedback, etc.);
  - reporting templates and companion documents to explain reporting templates in detail;
  - regular Executive Waiver Committee meetings to both communicate information and to solicit feedback from stakeholders; and
  - annual Statewide Learning Collaborative Summits.
- All of these venues provided an opportunity to solicit feedback and improve Demonstration processes, such as quarterly reporting and project modifications. In addition to continued communication with stakeholders, HHSC involved stakeholders in the development of the revised Category 3 outcomes and the Demonstration extension application.
- Updates found:

- Executive Summary and Overview: Stakeholders' Perceptions and Recommendations - Background for Evaluation Goals 10 and 11, Conclusions, The Demonstration Program Offered Opportunities and Challenges for Local Providers and Communities (pg. 25)

13. **Preliminary Results pg. 51:** The report proclaims there was a decrease in costly restorative and orthodontic dental services under managed care compared to fee-for-service [Evaluation Goals 3 and 4]. Please clarify whether a decrease in costly restorative dental services is a result of decrease in utilization of this service.

HHSC RESPONSE:

- The text has been updated to more accurately reflect the fact that costs were not analyzed for dental services.
- It is important to note there were no significant policy changes made to the Medicaid dental program that would have led to an anticipated change in utilization.
- The Conclusions section was updated to include: a list of results; an explanation that the reason(s) for changes in utilization cannot be determined through these analyses, but these changes could be attributable to more efficient delivery of services through MMC; and that a utilization review is necessary to determine the underlying causes.
- Updates found:
  - Appendix B: Conclusions, Summary of Results, Evaluation Goal 1: Access to Care, Access and Utilization of Dental Benefits (pg. 67)

14. **Access, Quality, Care Coordination, and Efficiency pg. 52**: The report indicates access to care for the STAR+PLUS population remained stable or improved as clients' service delivery model shifted from PCCM to MMC as measured by the rate of ambulatory visits. In the Executive Summary, the report explains it needs to evaluate further the LTSS population within STAR PLUS. Does the access to care data above include LTSS population? Please explain.

HHSC RESPONSE:

- Yes, the STAR+PLUS population includes clients that receive LTSS, but there is no stratification of results based on LTSS status. This stratification was not included in the Approved Evaluation Plan.

15. **Methodology:** Please discuss why the interrupted time series method was used for many of the STAR and STAR+PLUS expansion questions. With the expansion staggered over time and across regions, it is not apparent why the stronger difference-in-differences methodology could not have been used.

HHSC RESPONSE:

- Both interrupted time series and difference-in-difference methodologies were used to conduct analyses related to the expansion of and additional service carve-ins into MMC. While the difference-in-difference methodology may be considered stronger, appropriate comparison groups were not available for all analyses conducted. STAR and STAR+PLUS existed in predominantly urban service delivery areas (SDA) before the Demonstration began. When the Demonstration expanded STAR and STAR+PLUS to predominantly rural areas throughout the state, the existing managed care SDAs were deemed too different to serve as appropriate comparison groups; therefore, interrupted time series was selected so that trends in access to care could be measured both before and after the expansion of MMC.

16. **Presentation:** The color-coding of results was not effective when the report was printed using grayscale. This was especially noticeable with Table 1 of the report.

HHSC RESPONSE:

- The color scheme has been updated to allow for better visibility in black and white.

4.Regional Collaboration

Recommendations for strengthening the final evaluation report: Collaboration Section

Overall we view the collaboration evaluation as being responsive to the evaluation requirements. Nevertheless, we have several recommendations for how the evaluator could improve the final report; the first set of points relates to the organization and writing of the report and the second set covers more substantive issues.

Organization and Writing

1. Streamline and organize the report to better highlight the key findings and themes. The report contains a lot of useful information and explanations, but the text is quite dense. Various related information appears in disparate places and some important points are raised quite late in the report. A summary roadmap would help reader navigate the document. Greater use of bullets and summary statements, particularly for findings presented in the tables, would help the reader digest the information.

HHSC RESPONSE:

- The text has been updated to include bullet points and summary statements to highlight key findings.
- A more detailed explanation of the statewide results has been added to Appendix C.
    - Updates found:
        - Appendix C: Results, State-Level Results, Statewide Changes in Network Characteristics, 2012 to 2016 (pg. 15, Table 4)
- The conclusion has been updated with bullet points reflecting back on each hypothesis.
    - Updates found:
        - Appendix C: Conclusions (pg. 50-51)

2. More clearly delineate estimates that reflect a point in time from those that discuss change over time. Throughout the report there is some conflation of the two that is difficult to untangle.

HHSC RESPONSE:

- Text has been updated to clarify results that reflect point-in-time estimates versus results that reflect change over time.
- Updates found:
    - Executive Summary and Overview: Changes in Collaboration Among Organizations, Key Findings (pg. 16)
        - Throughout Appendix
            - Example: Results, State-Level Results (pg. 15)

Analysis

3. Provide more summary and reflection on the multiplexity findings. Given that multiplexity measures the strength of ties between two organizations, it seems that this measure merits more discussion in the final evaluation report.

HHSC RESPONSE:

- The text has been updated with additional explanation of all network findings, along with more discussion about potential implications.
- Updates found throughout Appendix C
    - Example: Conclusions (pgs. 48-51)

4. Expand discussion of qualitative findings, particularly on variation by type of organization, changes over time, and findings on other types of collaboration mentioned. To the extent the qualitative findings could be linked with the quantitative findings, would enrich the final evaluation report.

HHSC RESPONSE:

- The text has been updated to include more detail, where possible; as well as clarification that the qualitative data from EG 9 was not a verbatim transcript of the interview, but rather interviewer notes. Therefore, full thematic analysis and inclusion of direct quotes was not

appropriate. To the extent possible, the qualitative findings were used to provide context to aid in the interpretation of the quantitative findings.
- Updates found throughout Appendix C
    - Examples:
        - Results, RHP-Level Results, Collaboration to Deliver Programs and Services (pg. 24)
        - Results, RHP-Level Results, Collaboration to Share Tangible Resources (pg. 29)

5. Explore connections between findings and draw out implications of the findings. For example, more discussion about the centrality findings and what they might mean. Does this analysis shed light on the point from the literature that mandated networks are more likely to fail than those that develop organically?

HHSC RESPONSE:

- The text has been updated to include additional explanation of all network findings along with more discussion about potential implications.
- The Limitations section has been updated with discussion regarding mandated networks.
- Updates found throughout Appendix C
    - Example of explanation of network findings:
        - Conclusions (pgs. 48-51)
    - Limitations (pg. 51)

6. Did observed inter-organizational ties relate in any way to care processes or outcomes? Did the pattern of ties make sense from a care management perspective?

HHSC RESPONSE:

- The text has been updated to discuss how these relationships are related to care processes.
- Measurement of outcomes related to collaboration is beyond the scope of the Approved Evaluation Plan.
- Updates found:

- Appendix C: Results, RHP-Level Results, Collaboration to Deliver Programs and Services (pg. 24)

7. Provide more discussion of the literature on safety net collaboration, as well as state and local changes that might affect safety net collaboration, and how that research could help explain these findings.

HHSC RESPONSE:

- This comment cannot be addressed due to the following reason:
  - DSRIP was not specific to safety net providers, nor were they isolated as a distinct body of performing providers, so this is beyond the scope of the Approved Evaluation Plan.

8. Examine and integrate relevant findings from the stakeholder survey to present a fuller picture of the extent and ways in which RHP organizations are collaborating. The questions on facilitators and barriers to collaboration could help inform the network analysis findings. Similarly, the network analysis findings on collaboration with the Medicaid MCOs could be expanded as well and possibly integrated with the managed care evaluation.

HHSC RESPONSE:

- The Approved Evaluation Plan was not designed, and data collected are not appropriate, to triangulate results across research questions as requested; particularly as related to the network analysis findings being integrated with the managed care evaluation.

9. Further address some of the implicit research questions presented. The report sets up a few inquiries early in Appendix C that are not addressed later, such as geographic variation across the state, and how structural or contextual differences across RHPs may influence this variation. Even if the network analysis cannot address these questions, it would be useful to explain why.

HHSC RESPONSE:

- The text has been updated to include additional explanation of all network findings along with more discussion about potential implications, specifically:
    - The Tier analysis now discusses how those results can be interpreted in terms of geographic differences.
    - The Conclusion section now provides explicit links to each of the hypotheses tested under this evaluation goal.
- Please keep in mind that data were collected to describe trends in network formation / partnerships before and after the Demonstration, but are not necessarily sufficient to explain why these variations may exist.
- Updates found throughout Appendix C
    - Tier analysis explanation
        - Results, Results by Tier, (pg. 17)
    - Conclusions – links to hypotheses (pg. 50-51)

5.Other Questions

1. Does the evaluation team have any plans to submit the evaluation report (or any portion of it) to scholarly or professional journals for publication?

HHSC RESPONSE:

- The Final Evaluation Report includes Appendix H, which lists refereed and non-refereed papers/presentations.

- **NOTES:** HHSC reviewed this document. Each section has a table labeled "a" in which the *DRAFT* Final Evaluation Report is aligned with requirements in the STCs and a table labeled "b" in which the *DRAFT* Final Evaluation Report is aligned with the Approved Evaluation Plan. HHSC-CADS focused revision efforts on the "b" tables as the Final Evaluation Report is to meet the requirements outlined in the Approved Evaluation Plan, to the extent these requirements were feasible and possible to meet, given available data.

CMS Texas Draft Final Evaluation
Alignment with STC and Evaluation Design
March 7, 2017

CMS may defer up to $10 million in FFP if evaluation reports are not submitted on time or do not meet the requirements specified in the CMS-*approved evaluation plan* if the deficiency is material. CMS will work with HHSC to rectify issues with these reports prior to deferring any FFP.

1. Delivery System Reform Incentive Program (DSRIP)

a. Alignment with Special Terms and Conditions for the Texas DSRIP demonstration.

Table 1. How the DSRIP evaluation aligns with the special terms and conditions of the Texas DSRIP demonstration

Special terms and conditions	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
73(iii) Were the Regional Health Partnerships able to show quantifiable improvements on measures related to the goals	Partly met	The adjusted correlation analyses are most likely underpowered, unless the demonstration effects are relatively large. The evaluators report DSRIP CN projects are low-dose interventions in most cases and they serve a minority of the population eligible for these services. In addition, the evaluation did not assess outcomes at the RHP level, but at the project level.	The text has been updated in various places to describe the power analysis conducted, note models that were determined to be underpowered, and the limitations section has been updated to acknowledge this issue as well. Updates found: • Appendix E: Evaluation Design, Quantitative Analysis (pg. 31) • Appendix E: Results, Outcomes, DSRIP Care Navigation as a Predictor of Health Care Quality(pg. 68, 69) • Appendix E: Conclusions, Strengths and Limitations (pgs. 80) (already included from draft Final Evaluation Report) See response below to 73(c) Levels of analysis, for response about evaluation not assessing outcomes at the RHP level, but at the project level.

Special terms and conditions	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
73(iii)(A) Better care for individuals (including access to care, quality of care, health outcomes)	Met	Presented qualitative unadjusted and adjusted correlational analyses of 10 outcome measures. Most measures lacked the specificity and sensitivity necessary to draw conclusions about the results.	No response requested
73(iii)(B) Better health for the population	Partly met	Used well accepted SF-8™ composite measures of self-reported physical and mental health status among patients served by the DSRIP CN projects and two comparison sites. Given the small samples, these cannot be considered population health measures.	No response requested

73(iii)(C) Lower cost through improvement, especially with respect to per capita costs for Medicaid, uninsured, and underinsured populations, and the cost-effectiveness of care	Not met	The two cost measures were emergency department utilization measures.	Estimating cost for Medicaid, uninsured, and underinsured populations requires: 1) an all-payer claim system (which does not exist in Texas) and/or 2) an unduplicated count of DSRIP clients. Quantifiable Patient Impact (QPI) is by project and can be duplicated at the aggregate level. Given that ED costs are not able to be measured due to data limitations, inpatient hospitalization data were used as a proxy to estimate cost-effectiveness of care among the DSRIP CN projects. Updates found: • Executive Summary and Overview, Executive Summary (pgs. 6, 7) • Executive Summary and Overview; Effects on Health Care Quality, Population Health, and Costs; Evaluation Design (pg. 26) • Executive Summary and Overview; Key Findings; Outcomes Effects of DSRIP Care Navigation Receipt on Health Care Quality, Population Health, and Costs (pg. 30)

Special terms and conditions	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
			• Executive Summary and Overview; Conclusions (pg. 31) • Appendix E: Results, Outcomes, Hospital Encounters (pgs. 72-77) • Appendix E: Conclusions (p. 79) • Appendix E: Conclusions, Strengths and Limitations (pg. 80)
73(iii)(D) To what degree can improvements be attributed to the activities undertaken under DSRIP?	Not applicable	They did not find improvement is outcomes associated with DSRIP CN projects and did not address this question.	Not applicable due to null findings.
73(c) Levels of analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth	Partly met	All outcome analyses were at the patient level and some qualitative analyses presented were at the project level; there were no analyses at the aggregate program level.	DSRIP project-level was not included in the Final Evaluation Report because of the potential for sites to be identified. Sites selected for the evaluation (i.e., DSRIP and comparisons) were assured their responses would be kept private and confidential.

b. Alignment with the approved evaluation design plan

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
Comparative case study of one type of project	Met	The study used CN projects and the correlation analysis compared patient-level outcomes between DSRIP CN projects and comparison sites; however, the qualitative analyses were not comparative and focused on the DSRIP CN projects.	No response requested
Include four to nine RHPs	Met	Had 10 RHPs that implemented DSRIP CN projects and selected 10 comparison sites that did not. The plan suggested that the analysis would be longitudinal, but the final evaluation report does not include any longitudinal data and instead presents a cross-sectional analysis.	No response requested

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
The proposed sampling strategy will include at least one RHP serving a rural region of the state, one that serves an urban area, and one that serves a mix of rural and urban populations	Met	Although they received patient rosters from 15 of the 20 study sites, they obtained survey responses from patients at 13 sites (9 DSRIP CN projects and 4 comparison site). The two sites that provided patient rosters but then no one responded to the survey were rural and had small patient rosters, suggesting that rural regions were underrepresented in the analyses based on patient survey data.	No response requested

Interviews and focus groups would be used to understand how stakeholders experience system change	Partly met	Key informant interviews and focus groups with patients and their families were used. The final evaluation report does not provide information on stakeholder experiences over time as the DSRIP CN projects became more mature.	Updates found throughout Appendix E: • Appendix E: Results (throughout) - Qualitative findings are reported under the related quantitative sections to provide context for interpreting those data. ○ Example: (pg. 37), some rural projects "significantly reduced the scope of care navigation services currently provided" as a result of staff and funding shortages (already included from draft Final Evaluation Report). • Appendix E: Results, CN Project and Comparison Sites, Key Informant Characteristics (pg. 42), "the relatively low continuity in whom the team interviewed over time reflected frequently changing roles within DSRIP projects as well as some turnover." As a result, analysis of interview data often provided different key informant perspectives over time rather than comparisons over time in how the same key informants experienced system change. • Appendix E: Results, Context, Defining DSRIP Care Navigation (pg. 33) – description of initial effort expended to define CN and then constantly redefining and

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
			reassessing services, and making incremental changes No differences were identified between patient accounts of their care navigation experiences across waves.

The approved evaluation design plan suggests trend comparisons would be used, to the extent feasible	Not met	The evaluation does not include trend analyses. However, this component was conditional on its feasible, we assume a trend analysis was not possible, but the final evaluation report does not discuss this issue or why the patient survey was not designed to support a repeated cross sectional analysis; in addition, there was no indication in the interim evaluation report that trends based on the claims analysis conducted earlier could not be extended to more years of data.	The study team conducted two waves of the patient phone survey. However, after first wave of patients were surveyed, it was determined it would be best to survey a new panel of patients. This was primarily because at the time of initial surveying, the DSRIP care navigation projects were just starting, and evaluators wanted to measure the effects when the projects were more mature, and operating at full scale. This meant there was essentially one wave of the survey while the projects were active, insufficient for trend analysis A trend analysis was able to be conducted based on the inpatient hospitalization analysis for selected CN sites. The report has been updated to include this trend analysis based on quarter 1 of calendar year 2014 through quarter 4 of calendar year 2015. Results indicated a statistically significant decrease in hospitalizations one year after the onset of DSRIP CN. Updates found: • Appendix E: Results, Outcomes, Hospital Encounters: Logit Regression Predicting Hospital Encounters in First Year After Receiving CN (pg. 76, Table 45)

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
Outcome health indicators would be selected from reliable measures across multiple sites	Met	Used the SF-8™ composite measures for physical and mental health	No response requested

2. Stakeholder Analysis

a. Alignment with Special Terms and Conditions for the Texas DSRIP demonstration.

Table 3. Alignment of evaluation report's stakeholder analysis with the special terms and conditions of Texas' demonstration

Special terms and conditions	Addressed in the final evaluation report?	Comments	**Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response**
73.a.iv. How effective were the Regional Health Partnerships as a governing structure to coordinate, oversee, and finance payments for uncompensated care costs and incentives for delivery system reform? If issues were encountered, how were they addressed? What was the cost-effectiveness of DSRIP as a program to incentivize change? How did the amount paid in incentives compare with the amount of improvement achieved?	Partly met	The evaluator assesses RHP leadership, operations, involvement of member organizations, communication, perceived tension, and member satisfaction and perception of outcomes. We note that the evaluation does not address governance or fund flow, nor is the issue of the cost-effectiveness of DSRIP included. In addition, because the analyses are not longitudinal, the evaluation does not address the question about how issues encountered were addressed.	Updates regrading governance and fund flow may be found: • Appendix D: Background for Evaluation Goals 10 and 11 (pgs. 6-7) • Appendix D: Results, Module 1: Members' Experience with their RHP, Role and Influence of RHP Members (pg. 17) • Appendix D: Results, Module 3: Perspective from Non-Participating Organizations and Challenges of the Demonstration, Challenges (pg. 34) While the cost-effectiveness of DSRIP was not explicitly evaluated, Appendix E found that hospital utilization decreased for DSRIP CN sites, suggesting decreases in costs. RHPs did not address issues unilaterally. RHP Anchors and performing providers worked with Texas HHSC to address any issues. • Updates regarding how issues were addressed may be found: • Executive Summary and Overview, Stakeholders' Perceptions and Recommendations,~~:~~ Conclusions, The Demonstration Program Offered Opportunities and Challenges for Local Providers and Communities (p. 25)

73.a.v. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the UC and DSRIP pools? What changes would these stakeholders recommend to improve program operations and outcomes?	Partly met	The report assesses stakeholders' views on strengths and weakness of the demonstration and includes recommendations. However, the evaluator does not include individuals and families in their broader data collection efforts (their input is limited to the comparative case study on DSRIP CN projects).	There were several individuals and family members who responded to the stakeholder survey (those who had signed up to be on the Waiver email distribution list). However, in response to survey questions, they indicated that they didn't know enough about the components of the Waiver to comment, and their qualitative input focused on their personal situations and asking for help navigating the system. Stakeholders who felt knowledgeable enough about the Demonstration provided feedback and recommendations, which are represented in the report. Updates found: • Executive Summary and Overview, Stakeholder Perceptions and Recommendations, Evaluation Design (pg. 21) Additionally, outside of the formal evaluation, efforts to obtain stakeholder feedback regarding Medicaid managed care include: • HHSC held stakeholder meetings in 2015 to gather input on ways to improve the managed care landscape, from both the member and provider perspective. • Recommendations from various stakeholders and the agency's response were published in April 2016. The original response, and the July 2016 update can be accessed on HHSC's website: http://legacy-

Special terms and conditions	Addressed in the final evaluation report?	Comments	**Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response**
			hhsc.hhsc.state.tx.us/medicaid/managed-care/mmc.shtml. • In the July 2016 update, work plans have been developed to provide more detail about the agency response and plans for next steps. • Staff in the Medicaid and CHIP Services Department will reach out to stakeholder groups that provided feedback to discuss the responses and confirm the recommendations have been understood correctly and responses are clear from the perspective of the stakeholder. This document is updated quarterly. • HHSC recently reinstated the State Medicaid Managed Care Advisory Committee. This committee is charged with advising HHSC on the statewide operation of Medicaid managed care, including systemic concerns from consumers and providers. HHSC is committed to utilizing the expertise of this committee to continue the efforts started in 2015.

b. Alignment with the approved evaluation design plan

Table 4. Alignment of relevant aspects of the evaluation report with approved evaluation design

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
To address evaluation goals 10 and 11, the evaluator indicated that it would elicit 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.	Partly met	The report presents findings from a survey of stakeholders, including RHP anchoring institutions and performing providers, other organizational affiliations, and other stakeholders, including advocacy organizations. This survey assessed the overall demonstration (MMC, UC pool, and DSRIP). However, the report primarily relies on the comparative case study to provide patient and family input on the demonstration, and the input is limited to DSRIP CN projects rather than the overall demonstration.	EGs 10-11 were designed to obtain overall stakeholder feedback on the various aspects of the Demonstration (MMC, UC pool, and DSRIP) while EGs 6-8 were designed to provide a "deep dive" into one type of DSRIP project, ED care navigation. The stakeholder survey did not specifically target DSRIP project participants (i.e., clients or patients) as individual project participant information was not available. As stated above: There were several individuals and family members who responded to the stakeholder survey (those who had signed up to be on the Waiver email distribution list). However, in response to survey questions, they indicated that they didn't know enough about the components of the Waiver to comment, and their qualitative input focused on their personal situations and asking for help navigating the system. Stakeholders who felt knowledgeable enough about the Program provided feedback and recommendations, which are represented in the report.

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
The evaluation design specified the development of process indicators that would draw on stakeholder input, including increased communication among RHP stakeholders and increased coordination and collaboration among health service providers in each RHP (see Table 3 of Appendix G).	Met	The evaluation report addressed these topics.	No response requested

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
To assess the role of LC strategies in facilitating CQI among RHPs, the evaluator planned to use the RHPs' annual reports to identify LC topics and convene RHPs that are working on similar topics in an annual meeting in 2013 and through quarterly meetings to identify improvement plans and measurement strategies.	Partly met	The evaluator extracted information from each RHP plan and annual report for DY3 and DY4 update but did not include primary data collection with the RHP members beyond the comparative case study of DSRIP CN projects. The report provides no evidence that quarterly or additional annual meetings were held.	Evaluators conducted primary data collection during the DY4 reporting period. In consultation with HHSC-CADS staff, external evaluators developed a set of questions related to learning collaborative activities and made recommendations that they be added to the DY4 report. RHP responses to those questions were transferred to the external evaluators for analysis. This method is now clarified on: • Updates and previously included text found: ○ Appendix D: RHP Learning Collaboratives as a Quality Improvement Tool (pgs. 35-45) Annual or quarterly RHP meetings were outside the purview of the evaluation team. Instead, the evaluators presented preliminary results during the Statewide Learning Collaborative Summit in September of 2014 and as requested throughout the project.

3. Managed Care

a. Alignment with Special Terms and Conditions for the Texas DSRIP demonstration.

The evaluation report met one STC relevant to this component, partly met six, and did not address one. Table 5 compares the STCs with components of the MMC evaluation.

Table 5. How the MMC evaluation aligns with the special terms and conditions of the Texas MMC demonstration

Special terms and conditions	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
73(a)(i) What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?	Partly met	The evaluation report provides analyses of the MMC expansions and benefit changes on access to care, quality, efficiency, and coordination of care, but it does not provide analyses of how the costs of care have changed.	Any cost comparisons between the FFS and MMS is not feasible because differences in payment structures between FFS and MMC limit the validity of any service delivery model comparison for hospitalization costs and length of hospital stays. FFS hospital costs are restricted by federal law, but through the MMC service delivery model, MCOs contract with hospital providers and agree upon reimbursement rates for services provided to the MCO's clients. Because the State pays the MCO a capitated rate per member per month, the cost to Texas is not directly impacted by more expensive hospital payments under MMC. Capitated rates are adjusted every year and are actuarially sound.

Special terms and conditions	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
73(a)(i)(a) What is the impact of including pharmacy benefits in the capitated managed care benefit on access to prescription drugs? Does the effect vary by service area?	Partly met	This question is analyzed using descriptive trend data, but does not disaggregate the analysis by service area.	We reported descriptive trend analysis because there was an insufficient number of individuals in the eligible population for the selected measures to conduct interrupted time series analysis or stratify results by service delivery area.
73(a)(i)(b) What is the impact of managed dental care on the likelihood that children receive recommended dental services?	Yes	This question is analyzed using descriptive trend data for the receipt of at least one dental service in the past year.	No response requested
73(a)(i)(c) How does the State's 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? Would the same plans return approximately the same amounts to the State under a Medical Loss Ratio requirement as under the Experience Rebate, or would the results differ? Are there changes that could be made to either model to improve upon the intended purpose of such mechanisms?	Partly met	The evaluation report presents a comparative analysis of what each MCO paid under the Experience Rebate provisions and what they would have paid under the Medical Loss Ratio requirement. The report does not discuss whether the models ensure managed care plans "spend an appropriate amount of their premium revenue on medical expenses" and it does not address the types of changes that could be made to either model to improve upon their intended purposes.	Text has been updated to provide a description of the manner in which administrative costs and medical expenses are handled for the ER and the MLR. Additionally, there are brief suggestions to improve each model. • Updates found in Appendix B: Evaluation Goal 4 - Efficiency Improvements and Costs ○ ER and MLR: Cost-effective Spending versus Maximizing Medical Expenses (pg. 60) ○ Potential Improvements to the MLR and ER (pg. 65)

Special terms and conditions	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
73(a)(i)(d) What is the impact of including the non-behavioral health inpatient services in the STAR+PLUS program in terms of access to and quality of care and program financing?	Partly met	The evaluation report does not address this question directly, but indirectly through assessments of the effects of the MMC expansion on hospitalization rates. In some instances, the analyses were based on modeled estimates that adjusted for observable explanatory factors and in other instances the analyses were trends in descriptive statistics. The evaluation report does not assess the effect of this benefit change on program financing.	Any cost comparisons between the FFS and MMS is not feasible because differences in payment structures between FFS and MMC limit the validity of any service delivery model comparison for hospitalization costs and length of hospital stays. FFS hospital costs are restricted by federal law, but through the MMC service delivery model, MCOs contract with hospital providers and agree on reimbursement rates for services provided to the MCO's clients. Because the State pays the MCO a capitated rate per member per month, the cost to Texas is not directly impacted by more expensive hospital payments under MMC. Capitated rates are adjusted every year and are actuarially sound.

73(a)(i)(e) What is the impact of carving in behavioral health services to STAR and STAR+PLUS as compared to the carving out of behavioral health services in the service area of the North STAR 1915(b) waiver on coordination and quality of care?	**Partly met**	**The evaluation report presents difference-in-difference estimates for two measures of care coordination and does not present an analysis of any care quality measures.**	**Report has been updated to include difference-in-difference analysis of the behavioral health carve-in** • **Updates found:** ○ **Appendix B: Results, Evaluation Goal 3: Quality of Care (pg. 57, tables 33-34)**
73(a)(i)(f) What is the impact of the STAR+PLUS nursing facility carve-in on quality of care?	No	The evaluation report does not address this question.	Report has been updated to include analysis of the nursing facility carve-in. HHSC-CADS Evaluation waited to receive guidance from HHSC-CADS Data Quality Unit on new protocols to abstract and clean these claim data. Since nursing facility benefits were carved-in STAR+PLUS as of March 2015, there is only one year of post-data, which is insufficient to determine any impacts on quality of care. • Updates found: ○ Appendix B: Results, Evaluation Goal 3: Quality of Care (pgs. 59-60)

73(a)(v) What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program? What changes would these stakeholders recommend to improve program operations and outcomes?	Partly met	The final evaluation report provides information on perceptions and recommendations of providers, but we found no information on the perceptions and recommendations of health plans, beneficiaries and their families, or advocacy groups.	As stated above: There were several individuals and family members who responded to the stakeholder survey (those who had signed up to be on the Waiver email distribution list). However, in response to survey questions, they indicated that they didn't know enough about the components of the Waiver to comment, and their qualitative input focused on their personal situations and asking for help navigating the system. Stakeholders who felt knowledgeable enough about the Program provided feedback and recommendations, which are represented in the report. While Medicaid managed care (MMC) clients in expansion areas were not specifically interviewed regarding their shift from primary care case management or fee-for-service to MMC, the report has been updated to include results from the CAHPS® survey. Specifically, the question in which MMC clients are asked to rate their health plan on a scale of 0-10. Please note that, while the stakeholder survey didn't necessarily target MMC clients directly, several issues related to MMC are continuously monitored and evaluated by the external quality review organization and HHSC's Medicaid Quality team.

			• Updates found: ○ Appendix B: Results, Evaluation Goal 3: Quality of Care (pg. 58-59, tables 35-37)

b. Alignment with the approved evaluation design plan

Early in Texas's 1115 demonstration the State and CMS agreed to an approach to evaluate the changes to the MMC program. Appendix G of the final report includes the approved evaluation plan, which describes several different components to the analyses, most of which are addressed in the final evaluation report. Table 6 presents information that describes each component and what the final report addressed.

Table 6. How the MMC evaluation aligns with the approved evaluation design plan

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
Did expansion of STAR an STAR+PLUS impact access to care for the target population?			
Adult access to preventive/ambulatory health services	Yes	Used an interrupted time series analysis for STAR children and adolescents, and STAR+PLUS members.	No response requested
Number of STAR+PLUS members who had inpatient hospital stays per 1,000 members	Yes	Used an interrupted time series analysis.	No response requested

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
Top ten procedures utilized during hospitalizations for STAR+PLUS members who had inpatient hospital stays	No	No indication why this outcome measure was not analyzed and included in the final report, although the interim evaluation report included a series of charts showing the top five diagnoses for hospitalizations.	Report has been updated to include analysis of the top ten diagnoses for STAR+PLUS clients who had inpatient hospitalization stays. Diagnoses were reported instead of procedures as it made more sense in terms of determining *why* members were hospitalized. As an example, one of the most common procedures reported was room and board. These results were not included in the draft Final Evaluation because they weren't as useful in determining quality of care as the measure describing potentially preventable hospital admissions. • Updates found: ○ Appendix B: Results, Evaluation Goal 1: Access to Care (pgs. 32) ○ Appendix B: Supplementary Materials – Tables 54-59
Average number of miles from STAR+PLUS members to closest participating inpatient hospital in each new services area	Yes	Used descriptive statistics.	CADS Evaluation not only described these results, but also statistically tested the average number of miles from STAR+PLUS members to closest participating inpatient hospital (pg. 32).

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
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	No	The majority of the analyses of the changes in the dental benefits are based on the percentage of children with any type of dental service during the year.	Report has been updated to include analysis of children who received at least two dental check-ups in one calendar year. • Updates found: ○ Appendix B: Results, Evaluation Goal 1: Access to Care, Access and Utilization of Dental Benefits (pg. 43, Table 15)
Percent of children's Medicaid dental services members who receive at least one fluoride treatment of dental cleaning in one calendar year	No	Figure 10 provides data on the percentage of children who received preventive dental services, disaggregated by FFS and MMC, but how the measure was constructed is not explained in the report.	Report has been updated to include analysis of children who received at least one fluoride treatment in one calendar year. • Updates found: ○ Appendix B: Results, Evaluation Goal 1: Access to Care, Access and Utilization of Dental Benefits (pg. 43, Table 16)
Percent of children's Medicaid dental services members who receive at least one diagnostic dental service in one calendar year	Yes	Figure 10 provides this information disaggregated by FFS and MMC.	No response requested

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
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	Yes	Used descriptive statistics.	No response requested
Did the expansion of STAR and STAR+PLUS to the new service delivery areas impact care coordination for the target population?			
Percent of STAR and STAR+PLUS members in each new service area who felt their doctor was informed about the care they received from other providers	No	The report provides no information on why this outcome measure was not included.	Report has been updated to include results from the CAHPS® Survey question regarding how informed STAR and STAR+PLUS clients felt their personal doctor was informed about care received from other providers. It is important to note that survey results are reported at the state level as the sampling frame for the CAHPS® Survey was not appropriate for stratification by service delivery area, with a couple of exceptions in recent years which are included. • Updates found: ○ Appendix B: Results, Evaluation Goal 2: Care Coordination (pgs. 44-46, tables 17-19)

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
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	No	The report provides no information on why this research question was not addressed in the final report.	Enrollment broker services were not impacted by the 1115(a) waiver and these questions were removed from the STCs in 2013, and therefore were not evaluated.
Reasons for reassignment request	No	The report provides no information on why this research question was not addressed in the final report.	Enrollment broker services were not impacted by the 1115(a) waiver and these questions were removed from the STCs in 2013, and therefore not evaluated.
Have STAR and STAR+PLUS impacted preventable ED visits and hospitalizations over the demonstration period for the target population?			
Number of preventable emergency department visits per 1,000 members	Yes	Used an interrupted time series analysis.	No response requested
Number of preventable hospital admissions per 1,000 members	Yes	Used an interrupted time series analysis.	No response requested

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
Number of preventable hospital readmissions per 1,000 members	No	The report provides no information on why this outcome measure was not included.	Report has been updated to include analysis of the number of preventable hospital readmissions per 1,000 members. • Updates found: ○ Appendix B: Results, Evaluation Goal 3: Quality of Care, Preventable Hospital Readmissions (pg. 54, tables 27-28)
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	Yes	Used descriptive statistics.	No response requested
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	Yes	Used descriptive statistics and measured as per 1,000 members.	No response requested
What is the impact of the non-behavioral health inpatient services in the STAR+PLUS program in terms of cost?			

Design component	Addressed in the final evaluation report?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
Average cost of non-behavioral hospitalizations for STAR+PLUS members	No	The report provides no information on why this research question was not addressed in the final report.	Any cost comparison between the FFS and MMS is not feasible because the differences in payment structures between FFS and MMC limit the validity of any service delivery model comparison for hospitalization costs and length of hospital stays. FFS hospital costs are restricted by federal law, but through the MMC service delivery model, MCOs contract with hospital providers and agree on reimbursement rates for services provided to the MCO's clients. Because the State pays the MCO a capitated rate per member per month, the cost to Texas is not directly impacted by more expensive hospital payments under MMC. Capitated rates are adjusted every year and are actuarially sound.
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	Yes	The final report presents data on this measure, but does not address the question on whether the provision ensures that managed care plans spend an appropriate amount of their premium revenue on medical expenses.	No response requested

4.Regional Collaboration

a. Alignment with the STCs: Regional Collaboration

There appear to be no STCs directly related to the collaboration evaluation. However, parts of STCs 73(a)(iv) and (v) appear relevant to collaboration and the network analysis.

Table 7: How the collaboration evaluation aligns with the STCs

73(a)(iv). How effective were the Regional Health Partnerships as a governing structure to coordinate, oversee, and finance payments for uncompensated care costs and incentives for delivery system reform? If issues were encountered, how were they addressed? What was the cost-effectiveness of DSRIP as a program to incentivize change? How did the amount paid in incentives compare with the amount of improvement achieved?	**Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response**
Comments: The first two questions of this STC are relevant to the network analysis because they discuss the role of the RHPs as coordinators of incentives for delivery system reform, which could relate to ties between organizations to deliver programs and services, and share resources and data. The network analysis helps answer this question in part—particularly the centrality measure which helps illustrate the extent to which one or a few organizations lead the effort through a concentration of the ties. However, the network survey instrument and analysis does not ask about challenges to collaboration and this component of the overall state evaluation of the 1115 demonstration waiver does not address the question of how any issues were addressed.	Because the stakeholder survey was not designed to be longitudinal, there is not adequate data to examine within RHPs how issues were addressed. However, the data collected on the Learning Collaboratives does provide insight into the kinds of issues providers were concerned about in the delivery of different kinds of services, and how they shared information and experiences to improve quality of care. Previously included text found: • Appendix D: RHP Learning Collaboratives as a Quality Improvement Tool (pgs. 35-45)

73(a)(v). What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the UC and DSRIP pools? What changes would these stakeholders recommend to improve program operations and outcomes?	
Comments: Parts of this STC relate to the collaboration evaluation. The network survey provides insights into RHP organizations' perceptions, albeit on specific collaborations, but not about strengths and weaknesses. The separate survey to assess stakeholders' perceptions and recommendations task (Goals 10 and 11) includes a measure of collaboration, defined as the "degree to which partnership has increased cooperation, networking and information exchange." However, this measure of collaboration appears more general than the specific relationships between organizations that the network analysis captures. The survey includes questions on how RHPs managed their collaborations and found, for example, that two-thirds of respondents reported that their RHP had "set ground rules for working together" and that the average respondent felt the RHP requirement was increasing collaboration among organizations to improve access to health services. For more detail, please see our separate memo on the evaluation of the stakeholder perceptions' component. Also, the evaluation report states that the stakeholder survey findings will provide context for understanding the collaboration evaluation results at the conclusion of the evaluation, but the exact timing is not stated.	Because the same team conducted analysis of the stakeholder survey and the network surveys, stakeholder input was able to be used as context for understanding the dynamics of changes in network characteristics across RHPs and across the state as a whole.

Additionally, the STCs mention collaboration broadly, establishing how DSRIP and the RHPs are intended to foster collaboration. It lays out in detail how RHP plans should include strategies to implement collaborative interventions that involve data sharing to reduce disparities, enhancing oral health services through partnerships among dental schools and health care providers, and

providing/integrating behavioral health services between medical and behavioral health providers. The network analysis touches on these topics at a high level—as mentioned earlier, the qualitative findings discuss some of these specific services and the quantitative findings demonstrate new relationships with new types of organizations, particularly the community mental health centers—but does not address them in detail.

b. Alignment with the approved evaluation design plan: Regional Collaboration

Early in the 1115 demonstration, Texas and CMS agreed to an approach to evaluating the collaboration component. Appendix G of the final report includes the approved evaluation plan, which states that evaluation goal 9 falls under the evaluation plan for the formation of the RHP regions (Intervention 2). However, the appendix includes few mentions of how collaboration should be evaluated. It mentions a "social network analysis" but it is unclear if this statement refers to the network analysis discussed in this memo or something else. Also, the evaluation logic model for the DSRIP health system transformation does not mention collaboration as a key activity or process.

Table 8 presents the design components discussed in Appendix G that reference collaboration within RHPs and the extent to which these are addressed in the final evaluation report draft.

Table 8. How the collaboration evaluation aligns with the approved evaluation plan

Design component	Addressed in the final evaluation report draft?	Comments	Texas HHSC Center for Analytic and Decision Support (CADS) Evaluation response
References possible data collected to include: each RHP's formal governance structure; social network analysis measuring the relationship of RHP stakeholders, their interest, power dynamics, and resource exchange within each initiative.	Partly met	The network analysis covered the number and types of relationships between RHP organizations but did not cover these other topics.	The design component references *possible* data to be collected. Information about formal governance structure was abstracted from the initial RHP plans (not all RHPs developed a formal governance structure). Data were collected and reported regarding social network analysis measuring the relationship of RHP stakeholders, and resource exchange (resource sharing construct – see Appendix C, Table 2, pg. 12).
One performance measure/indicator for Intervention 2 is "Increased coordination and collaboration among health services providers in each RHP," as measured by RHP stakeholder focus groups and structured interviews in DY2 and DY4.	Met	The network analysis surveyed / interviewed the providers in each RHP. However, focus groups of RHP stakeholders were not held for this analysis.	No response requested