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Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals

Aggregate Evaluation Plan: Executive Summary

Prepared for

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EXECUTIVE SUMMARY

The Medicare-Medicaid Coordination Office (MMCO) and Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Financial Alignment Initiative to test integrated care models for beneficiaries who are dually eligible for Medicare and Medicaid (Medicare-Medicaid enrollees). The goal of the Financial Alignment Initiative is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports (LTSS) for Medicare-Medicaid enrollees.

CMS contracted with RTI International to monitor the implementation of the demonstrations and to evaluate their impact over time on beneficiary experience, quality, utilization, and cost. This report describes the *Aggregate Evaluation Plan* that will guide the overall evaluation. RTI will develop separate State Evaluation Reports for each individual State participating in the Financial Alignment Initiative. The activities described in this report may be revised if modifications are made to the demonstrations or if other circumstances change during the demonstration period. Although this document will not be revised to address all changes that may occur, the annual and final evaluation reports will note areas where the evaluation as executed differs from this evaluation plan.

Section 1—Introduction

The goals of RTI's evaluation are to monitor each State's demonstration implementation, evaluate the impact of these demonstrations on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstrations' impact on a range of outcomes for the eligible populations as a whole and for subpopulations (e.g., people with mental and/or substance use disorders, LTSS recipients). To achieve these goals, RTI will collect qualitative and quantitative data from States quarterly; analyze Medicare and Medicaid enrollment, claims, and encounter data, and data from the Nursing Home Minimum Data Set (MDS); conduct site visits and interviews with staff involved in the demonstration, beneficiary focus groups, and key stakeholder interviews; and incorporate relevant findings from beneficiary surveys.

RTI will report preliminary information to CMS in an initial 6-month implementation report and quarterly data reports to CMS and States. RTI will also integrate this information into annual State-specific and cross-cutting reports and a final evaluation report. The key research questions and data sources for the evaluation are summarized in ***Table ES-1***.

The principal focus of the evaluation will be at the State level. CMS has engaged an operations support contractor to monitor fulfillment of the demonstration requirements outlined in the Memoranda of Understanding (MOUs), contracts, and final agreements, including Medicare-Medicaid Plan (MMP)-level monitoring in capitated States. RTI will integrate that information into the evaluation as appropriate.

Table ES-1
Research questions and data sources

Research questions	Stakeholder interviews and site visits	Beneficiary focus groups	Claims and encounter data analysis	Demonstration statistics[1]
1) What are the primary design features of each State's demonstration and how do they differ from the State's previous systems?	X	X	—	X
2) To what extent did each State implement its demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—	X
3) What impact do these demonstrations have on the beneficiary experience overall, by State and for beneficiary subgroups? Do beneficiaries perceive improvements in how they seek care, choice of care options, how care is delivered, personal health outcomes and quality of life?	X	X	—	X
4) What impact do the demonstrations have on cost and is there evidence of cost savings in each State? How long did it take to observe cost savings in each State? How were these savings achieved in each State?	—	—	X	—
5) What impact do these demonstrations have on utilization patterns in acute, long-term, and behavioral health services, overall, by State, and for beneficiary subgroups?	X	X	X	X
6) What impact do these demonstrations have on health care quality overall, by State, and for beneficiary subgroups?	—	—	X	X
7) Does the demonstration change access to care for medical, behavioral health, long-term services and supports (LTSS) overall and for beneficiary subgroups, by State? If so, how?	X	X	X	X
8) What policies, procedures, or practices implemented by each State in its demonstration can inform adaptation or replication by other States?	X	X	—	X
9) What strategies used or challenges encountered by each State in its demonstration can inform adaptation or replication by other States?	X	X	—	X

— = not applicable

[1] Demonstration statistics refer to data that States, CMS, or other entities will provide regarding topics including enrollments, disenrollments, grievances, appeals, and number of health and/or medical homes. States will be providing quarterly data updates through the State Data Reporting System. States will also submit reports summarizing findings of any external quality review organization analyses, beneficiary surveys, and other quality monitoring activities required by CMS or undertaken by the States during the demonstration period.

Section 2—Demonstration Implementation

The evaluation of demonstration implementation will be based on case study methods and quantitative data analysis of enrollment patterns and is designed to answer the following overarching research questions:

- What are the primary features of each State demonstration, and how do they differ from the State's previous system available to the demonstration-eligible population?
- To what extent did each State implement the demonstration as proposed?
- Which States were able to fully implement their intended proposals?
- Were certain models more easily implemented than others?
- Were the demonstrations more easily implemented for certain subgroups?
- What factors contributed to successful implementation?
- What were the barriers to implementation?
- How have beneficiaries participated in the ongoing implementation and monitoring of the demonstrations?
- What strategies used or challenges encountered by each State can inform adaptation or replication by other States?

Demonstration Design Features. RTI will examine how each States' strategies and demonstration design features translate at the plan or practice level. ***Table ES-2*** lists the design features, and examples of key components of design features, that RTI will monitor. Table 3 in Section 2 of this report contains a more complete listing.

Table 4 in Section 2 of this report provides a comprehensive list of implementation tracking elements that RTI will monitor for each design feature. Examples include State efforts to build MMP and provider core competencies for serving beneficiaries with various disability types; State requirements for coordination and integration of clinical, LTSS, and behavioral health services; documentation of coordination activities between MMPs and community-based organizations; phase-in of new or enhanced benefits, and methods to communicate them to eligible populations; and strategies for expanding beneficiary access to demonstration benefits.

As part of the implementation evaluation, the design features will be used in descriptive and comparative analyses across States. Additionally, the design features will be used in quality, utilization, access to care, and cost analyses to identify demonstration characteristics associated with better outcomes.

Table ES-2
Demonstration design features and examples of key components
(see Table 3 of this report for more detail)

Integrated delivery system

- Primary care, including medical homes and health homes
- LTSS
- Behavioral health services
- Developmental disability services

Integrated delivery systems supports

- Care team composition
- Health IT applied throughout the demonstration (at State level, by MMPs, at provider level or other)

Care coordination/case management

- Assessment process
- Service planning process
- Care management stratification process

Benefits and services

- Scope of services/benefits
- New or enhanced services

Enrollment and access to care

- Integrated enrollment and access to care
- Provider accessibility standards
- Opt out, disenrollment, and auto assignment policy

Beneficiary engagement and protections

- State policies to integrate Medicare and Medicaid grievances and appeals
- Quality management systems

Financing and payment elements

- Financing model: capitation or managed fee for service
- Incentives
- Shared savings

LTSS = Long-term services and supports; MMP = Medicare-Medicaid Plan; IT = information technology.

RTI will also track implementation progress indicators using data that States report quarterly through the State Data Reporting System (SDRS—see Section 4 of this report for more information), and other data that RTI obtains. ***Table ES-3*** presents examples of progress indicators that RTI will track through the SDRS and include in preliminary quarterly monitoring reports to CMS and the States.

Table ES-3
Examples of SDRS progress indicators

Indicator
No. of individuals…
— eligible to participate in the demonstration
— currently enrolled in the demonstration
— passively enrolled in the demonstration
— who opted out of the demonstration prior to enrollment
— who voluntarily disenrolled from the demonstration
— whose enrollment in the demonstration ended (e.g., death, loss of eligibility)

SDRS = State Data Reporting System.

Data Sources. RTI will use a variety of data sources to assess the implementation of each demonstration, including State documents (e.g., MOUs, waivers, contracts, State Plan Amendments); quarterly SDRS data submissions; and interviews with State agency staff, stakeholders, and coordinated care organizations/providers conducted during two site visits to each State and by telephone.

Section 3—Beneficiary Experience

The impact each State demonstration has on beneficiary experience is an important focus of the evaluation. RTI will monitor and evaluate the experiences of beneficiaries, their families, and caregivers to assess how closely the demonstrations meet CMS's goal of designing person-centered care delivery models. RTI will address the following research questions:

- What impact do these demonstrations have on beneficiary experience overall, by State, and for beneficiary subgroups?
- What factors influence the beneficiary enrollment decision?
- Do beneficiaries perceive improvements in their ability to find needed health services?
- Do beneficiaries perceive improvements in their choice of care options, including self-direction?
- Do beneficiaries perceive improvements in how care is delivered?
- Do beneficiaries perceive improvements in their personal health outcomes?
- Do beneficiaries perceive improvements in their quality of life?

RTI's framework for evaluating beneficiary experience is influenced by work conducted by the Center for Health Care Strategies (CHCS) on the elements of integration that directly affect beneficiary experience for Medicare-Medicaid enrollees. Table 6 in Section 3 of this report aligns key elements identified in the CHCS framework with the demonstration design features described previously, and ***Table ES-4*** provides examples of these elements that the evaluation will monitor.

Table ES-4
Examples of assessing beneficiary experience by beneficiary impact
(see Table 6 of this report for more detail)

Integrated delivery system
Beneficiaries have choice of medical, behavioral, and LTSS services and providers.
Beneficiaries are empowered and supported to make informed decisions.
Beneficiaries report that LTSS and behavioral health are integrated into primary and specialty care delivery.
Beneficiary burden is reduced through elimination of duplicative tests and procedures.
Delivery systems supports
Beneficiaries report that providers are knowledgeable about them and their care history.
Beneficiaries report adequacy of discharge and referral instructions.
Beneficiaries report that providers follow up after visits or discharge.
Care coordination/case management
Assessment process integrates/addresses health, behavioral health, and LTSS.
Beneficiaries report that they actively participate in the assessment process as do their medical providers.
The system facilitates timely and appropriate referrals and transitions within and across services and settings.
Benefits and services
Beneficiaries are aware of covered and enhanced benefits and use them.
The demonstration covers important services to improve care outcomes that are not otherwise available through the Medicaid or Medicare program.
Enrollment and access to care
Beneficiaries have choices and assistance in understanding their enrollment options, and they report ease of disenrollment.
Beneficiaries can access the full range of scheduled and urgent medical care, behavioral health services, and LTSS.
Beneficiaries report improved quality of life as a result of access to the full range of services.
Beneficiaries have access to multilingual and culturally sensitive providers.
Beneficiary engagement and protections
Beneficiaries understand their rights, and they get assistance in exercising their rights and protections.
Beneficiaries are treated fairly, are informed of their choices, and have a strong and respected voice in decisions about their care and support services.
Beneficiaries have easy access to fair, timely, and responsive processes when problems occur.
Finance and payment
Beneficiary experience is taken into account when awarding provider and plan incentives.

LTSS = Long-term services and supports.

NOTE: Data sources for assessing beneficiary experience include stakeholder interviews, beneficiary focus groups, survey questions, demonstration data, and interviews with State agency staff on demonstration implementation.

Data Sources. RTI will solicit direct feedback from beneficiaries through *focus groups* to gain insight into how the initiative affects them. There will be four focus groups in each State with 8 to 10 individuals in each group. Based on a State's enrolled population, each focus group will include a cross-section of individuals.

RTI will review and include in the evaluation as appropriate the results of *beneficiary surveys* administered by the State, CMS, or other entities. RTI will not directly administer beneficiary surveys as part of the evaluation and is not requiring States to administer beneficiary surveys for this evaluation. Several States have proposed to administer a beneficiary survey as part of their demonstrations. RTI will work with States, CMS, or other entities to incorporate these data into the evaluation.

Per the capitated model demonstration requirements outlined in MOUs and three-way contracts, Healthcare Effectiveness Data and Information Set (HEDIS), Health Outcomes Survey (HOS), and Consumer Assessment of Healthcare Providers and Systems (CAHPS) must be reported consistent with Medicare requirements. The operations support contractor for CMS will administer a CAHPs survey in managed fee-for-service (MFFS) States. RTI will work with States and CMS to acquire the results of these surveys and incorporate them into the evaluation as appropriate.

RTI will also conduct key *stakeholder interviews* to better understand the level of beneficiary engagement with the demonstration, its perceived impact on beneficiary outcomes, and any unintended consequences. RTI will conduct interviews with members of beneficiary groups whose stakeholders are served by a State's demonstration, such as members of consumer advisory groups, beneficiary rights advocates, and public guardian groups.

Finally, RTI will use *other data* collected from States during site visits, reports, and other materials developed by States, the SDRS, and data obtained from CMS or other entities to assess the beneficiary experience. Data of particular interest include, but are not limited to, the following:

- Complaint, appeal, and grievance data from CMS, demonstration Ombuds programs, or other entities, as available.
- Disenrollment and opt-out rates, where appropriate.
- Information about waiting lists or lags in accessing services, which will provide useful indications of where the system lacks capacity, as a topic for discussion during site visits or focus groups.

RTI will explore whether specific demonstration features can be identified in each State that affect beneficiary experience and, where possible, how those features also affect evaluation findings through quantitative analyses of quality, utilization, and costs.

Section 4—State Data Reporting System (SDRS)

The SDRS will be RTI's tool for collecting and storing information about each State's demonstration design and progress, and monitoring and reporting on demonstration progress by individual States and the Financial Alignment Initiative as a whole. The SDRS will store model summary, implementation tracking, and demonstration impact and outcomes data to be used in the quarterly preliminary reports for CMS and States as well as in annual aggregate and State-specific reports.

Data Stored in the SDRS. The *model summary* data describe each State's demonstration model, such as geographic areas, new services offered, and eligible populations (see Table 10 of this report for more detail). RTI will input this information into the SDRS and will update it only if there are changes to a State's demonstration.

States will input *implementation tracking* data into the SDRS on a quarterly basis. States will report numerical Progress Indicators data, including those presented in ***Table ES-5*** and in Table 11 of this report. States will also enter data via the Tracking Elements by Design Feature subsection of the SDRS, which includes Yes/No and free text responses. ***Table ES-6*** (and Table 12 of this report) present examples. See Section 5 of this report for more information.

Table ES-5
SDRS data collection: Progress indicator elements

Indicator[1]
Eligibility
Total number of beneficiaries who are eligible to participate in the demonstration[2]
Enrollment
Total number of beneficiaries who are enrolled in the demonstration[2]
Number of beneficiaries who are newly enrolled in the demonstration[2]
Number of newly enrolled beneficiaries who were automatically (passively) enrolled in the demonstration[2]
Number of beneficiaries who opted out or chose not to enroll in the demonstration without ever being enrolled[2]
Disenrollment
Number of beneficiaries who voluntarily disenrolled (i.e., made a choice to disenroll) from the demonstration[2]
Number of demonstration enrollees whose eligibility for the demonstration ended involuntarily (e.g., moved out of area, lost Medicaid eligibility, were incarcerated)[2]
Demonstration service area
Whether demonstration is currently operating statewide vs. in specific counties or geographic areas (and provide list of counties served, if in specific geographic areas)
Specific to capitated model demonstrations
Number of three-way contracts with MMPs
New CMS initiatives in the demonstration area that may affect Medicare-Medicaid enrollees
Specific to demonstrations that use health homes
Number of health homes participating in the demonstration
Number of enrollees served by health homes
Specific to demonstrations using medical homes
Number of medical homes participating in the demonstration
Number of enrollees served by medical homes

LTSS = long-term services and supports; MFFS = managed fee for service; MMP = Medicare-Medicaid plan; NCQA = National Committee for Quality Assurance; SDRS = State Data Reporting System.

[1] All indicators may not apply to all States (e.g., for some MFFS States, beneficiaries who are eligible for the demonstration are the same as beneficiaries who are enrolled in the demonstration).

[2] Progress indicators that will be presented in quarterly reports to CMS and the States.

Table ES-6
SDRS data collection: Examples of tracking elements by design feature
(see Table 12 of this report for more detail)

Integrated delivery systems
New policies or administrative procedures for improving the integration of primary care, long-term services and supports (LTSS), and behavioral health services under the demonstration
Changes in reporting requirements for any of the entities involved in the demonstration
Integrated delivery systems supports
Training or capacity-building activities to build core competencies of demonstration MMPs/providers in serving demonstration populations
Activities to help primary care providers transform care delivery
Care coordination/case management
New State policies/guidelines regarding care coordination/case management, promoting the adoption of electronic health records, etc.
Benefits and services
New or expanded services/benefits for demonstration participants
Enrollment and access to care
Activities to increase beneficiary enrollment
Major issues and challenges implementing the demonstration and solutions developed
Beneficiary engagement and protections
Activities to engage stakeholders in policy development or oversight of the demonstration
Activities to engage enrollees, families, or advocates in policy development or oversight of the demonstration
Quality management and measurement
Tracking of new quality indicators
Receiving data from MMPs/providers to support new quality indicators
Financing and payment
Changes in payment methodology for MMPs and providers
Data development
Timing of the most recent MSIS or T-MSIS data file submissions
Whether MMPs experienced any problems submitting encounter data to CMS (for capitated models)
Successes related to the demonstration not covered by other questions

MMP = Medicare-Medicaid Plan; MSIS = Medicaid Statistical Information System; SDRS = State Data Reporting System; T-MSIS = Transformed Medicaid Statistical Information System.

RTI will input *demonstration impact and outcomes* data into the SDRS on a quarterly basis. This content will be generated by RTI from Medicaid Statistical Information System (MSIS)/Medicare fee-for-service (FFS) claims; encounter data from MMPs, Medicaid managed care organizations, and Medicare Advantage plans; Nursing Home MDS analysis; and other data that may be available. Data availability will affect when specific analysis results will be reported.

Section 5—Quantitative Analyses

RTI will conduct quantitative analyses for individual States and will include them in annual reports. The final evaluation report will also include an aggregate analysis to learn more about the effects of different State demonstration design features on quality, utilization, and costs. Different analytic approaches are required for MFFS States versus capitated model States in terms of data requirements, analytic issues, and outcome variables. This section of the report discusses the overall approach to identifying demonstration group and comparison group beneficiaries. For State-specific details on identifying demonstration and comparison groups, see the State-specific evaluation design reports.

Research Approach. RTI will use an intent-to-treat (ITT) approach for the quantitative analyses, comparing the eligible population for each State's demonstration with a similar population that is not affected by the demonstration (i.e., a comparison group). Under the ITT framework, outcome analyses will include all beneficiaries eligible for the demonstration in the demonstration States, including those who opt out, participate but then disenroll, are eligible but are not contacted by the State or participating providers, and those who enroll but do not engage with the care model, and a group of similar individuals in the comparison group. This approach diminishes the potential for selection bias and highlights the effect of the demonstrations on all beneficiaries in the demonstration-eligible population. RTI will compare the characteristics of those who enroll with those who are eligible but do not enroll in the care model and will conduct analyses to further explore demonstration effects on demonstration enrollees, acknowledging that selection bias must be taken into account in interpreting the results.

Demonstration Groups. To identify the population eligible for a State's demonstration, States will submit demonstration evaluation (finder) files to RTI on a quarterly basis that will include information on enrolled beneficiaries as well as all beneficiaries eligible for the demonstration. RTI will use this information to identify the characteristics of each State's eligible beneficiaries. Section 5 of this report provides more detail on the content of the demonstration evaluation (finder) files.

Comparison Groups. In this evaluation design, the comparison group provides an estimate of what would have happened to the demonstration group in the absence of the demonstration. Thus, the comparison group members should be similar to the demonstration group members in terms of characteristics, including health care and LTSS needs, and should reside in areas similar to the demonstration areas in terms of the health care system and the larger environment. Identifying the comparison group members will entail two steps: (1) selecting the geographic area from which the comparison group will be drawn and (2) identifying the individuals who will be included in the comparison group.

RTI will determine whether an in-State comparison group is possible for each demonstration State. An in-State comparison group will only be a potential option for demonstrations

implemented in a subset of the State, rather than statewide, where the demonstration and nondemonstration areas are similar, and where the nondemonstration areas contain sufficient numbers of beneficiaries. For States where an in-State comparison group is not possible, we will develop an out-of-State comparison group or, potentially, a comparison group that includes both in-State and out-of-State areas.

To construct a comparison group from out-of-State areas, or a combination of in-State and out-of-State areas, we will limit potential comparison areas to those not participating in the Financial Alignment Initiative. We expect to draw out-of-State comparison groups using areas from multiple comparison States. The areas included in the comparison group will be determined by the closeness of the match with the demonstration areas, and the size of the Medicare-Medicaid enrollee population in the comparison area. The goal will be to identify a comparison group at least as large as the demonstration group to ensure a sufficient sample to support sensitivity analyses around the choice of comparison groups. The first annual report will document decision rules for choosing the comparison area.

To identify comparison areas, RTI will conduct a statistical distance analysis to assess the similarity of a demonstration region with each of its potential comparison areas. The process entails the following three steps:

Step 1. Identify characteristics that will be used to compare demonstration and comparison areas that reflect State-level policies prior to the demonstration. Example characteristics include the following:

- Medicare spending per Medicare-Medicaid enrollee
- Medicaid spending per Medicare-Medicaid enrollee
- Nursing facility users per Medicaid beneficiary age 65 and over
- Home and community-based services (HCBS) users per Medicaid beneficiary age 65 and over
- Personal Care users per Medicaid beneficiary age 65 and over
- Medicare Advantage penetration
- Medicaid managed care penetration per full-benefit Medicare-Medicaid enrollee

Step 2. Compute statistical distance scores for each demonstration area and potential comparison Metropolitan Statistical Areas (MSAs) to measure the similarity between the demonstration population and a potential comparison population. The smaller the distance score, the more similar the States are with respect to the selected characteristics. This step will occur when the final list of demonstration States is confirmed, so the most recent data available can be used and the full range of potential comparison areas is known. More detail is provided in Section 5 of this report.

Step 3. Select comparison areas by identifying the comparison areas with the smallest statistical distance scores. The number of areas to be selected will depend on their combined population of Medicare-Medicaid enrollees. RTI will also consider other factors, including the timeliness of a State's MSIS submissions.

To identify the individuals within the comparison geographic areas to include in the comparison group, RTI will estimate propensity scores and weight comparison group beneficiaries so that the distribution of selected characteristics looks like the demonstration group. For this evaluation, the propensity score is an estimate of the probability that a beneficiary is in the demonstration group conditional on a set of observed characteristics. The following characteristics are examples of those that may be included in the propensity model:

- Beneficiary characteristics such as age, sex, MSIS eligibility information on socioeconomic status, prior Medicare and Medicaid expenditures, LTSS/HCBS, hierarchical condition category (HCC) risk scores, and end stage renal disease (ESRD) status. These data will be obtained from Medicare and Medicaid files and will include encounter data or per member per month (PMPM) payments where appropriate and available.
- MSA-level characteristics from Census Bureau databases, and the Area Resource File (ARF) such as health care providers/100,000 population, morbidity/mortality, and urbanicity.
- State-level policy factors, such as the proportion of long-term services and supports spending that is for HCBS (rather than for facility-based care), Medicaid nursing facility eligibility criteria, and implementation of Health Home State Plan Amendment (SPA; except for within-State comparison groups).

RTI will estimate a logistic model by regressing group status (demonstration vs. comparison pool) on the set of individual and area characteristics to determine the propensity scores for demonstration and comparison group beneficiaries. Comparison group members will then be weighted by their predicted propensity score to ensure that the comparison group reflects the distribution of characteristics in the demonstration population.

The comparison areas will be determined within the first year of implementation of each demonstration, in order to use the timeliest data available. The comparison group members will be determined retrospectively at the end of each demonstration year, allowing us to include information on individuals newly eligible or ineligible for the demonstration during that year. The groups will be refreshed annually to incorporate individuals who become eligible for the demonstration over time. Section 5 of this report provides more detail on this process.

The demonstrations under the Financial Alignment Initiative will be implemented during a period when several other CMS demonstrations and initiatives are occurring. As part of our analytic framework using multivariate analyses in the last year of the evaluation, RTI will work to identify any demonstration impact beyond that resulting from other demonstrations and programs, as appropriate.

Data Sources. RTI will use several data sources for the quantitative analysis. To identify beneficiaries eligible for the demonstration, a State will provide demonstration evaluation (finder) files described earlier and in Section 5 of this report. From CMS, RTI will use

Medicare enrollment data, claims, and Nursing Home MDS for the predemonstration and demonstration periods, where appropriate, to create a beneficiary-level file with summary variables on Medicare utilization and payment by service type (e.g., inpatient, skilled nursing, home health). Medicaid claims data will be used to construct service use patterns, particularly for services not covered by Medicare—notably, facility-based long-term care, HCBS waiver services, and behavioral health services. Because the evaluation uses an intent-to-treat design and includes a predemonstration period, RTI will use CMS encounter data from Medicare Advantage plans, nondemonstration Medicaid managed care plans, and MMPs to capture utilization of beneficiaries receiving services through managed care. RTI will also obtain CMS data on prescription drug PMPM payments for beneficiaries from the monthly plan payment files at CMS, and potentially Part D reconciliation costs directly from the CMS payment group, to support analysis of Part D costs.

Section 5 of this report provides more detail on how the analytic files will be constructed, including possible challenges.

Section 6—Analysis Overview

Quantitative analyses of quality, utilization, and cost will be performed for each demonstration State and in the aggregate for the Financial Alignment Initiative as a whole. Sections 7, 8, and 9 of this report describe the quality, utilization, and cost measures that will be examined. This section outlines the methods that RTI will use to analyze those data. The timing of the quantitative analyses will depend on data availability (as discussed in Section 5 of this report); the methods outlined here may be modified to incorporate any changes that may occur in States unrelated to the demonstration, such as the effects of other demonstrations or State-specific policy changes.

Monitoring. RTI will track quarterly changes in individual States for selected beneficiary experience, quality, utilization, access to care, and cost measures for the demonstration group using pre- and postperiod data analyzed by RTI and stored in the SDRS. RTI will use available Medicare and Medicaid data each quarter to calculate means, counts, and proportions for selected measures. RTI will also analyze available Nursing Home MDS data to calculate facility admission rates. The monitoring analysis will be used to develop the quarterly reports for CMS and the States.

Individual State Descriptive Analyses. RTI will conduct individual-State descriptive analyses at the end of each demonstration period[1] that focus on beneficiary experience, utilization, access to care, cost, and quality measures, as well as changes across time or subgroups of interest within each demonstration period. Examples of measures include total costs for Medicare and Medicaid separately, primary and specialty care utilization rates,

[1] Demonstration period as defined in each State's MOU.

rates of avoidable hospitalization and inappropriate readmissions, counts of hospital and nursing facility admissions and length of stay, rates of HCBS use, and mortality. More information on the measures to be reported can be found in Sections 7 to 9 of this report. RTI will present means, counts, and proportions; and statistical tests of means and counts for the 2-year baseline period, each demonstration period, and the comparison group. RTI will also provide results comparing beneficiary subgroups by age groups, subpopulations, and other important characteristics to inform CMS and States about improvements over time. The results of these analyses will be presented in an annual report for each State.

Impact Analyses Within States. RTI will assess the overall impact of the demonstration on quality, utilization, and cost measures using a difference-in-differences method with a comparison group for the final evaluation report for each State. This multivariate analysis will be done after the demonstration is complete to allow for sufficient claims run-out for the demonstration State and the comparison areas, to avoid over- or underestimates of results. Under the difference-in-differences method, pre- and postdemonstration changes in the outcome measures (e.g., utilization, quality, cost measures) for the demonstration group will be compared with the pre- and postexperience of a comparison group. This methodological framework will also be applied to each of the quality, utilization, access to care, and cost measures that will be tracked within each State over time. These analyses will use linked Medicare and Medicaid claims and encounter data for the predemonstration and demonstration period. RTI will finalize the specific outcome measures for the difference-in-differences analyses after the demonstration has concluded to ensure that comparable, high-quality data are available for the demonstration and comparison States.

More details on the multivariate analyses, including the regression equations that will be used, can be found in Section 6 of this report.

Sensitivity Analyses. RTI will test the sensitivity of the impact estimates for State demonstrations because the validity of the difference-in-differences approach depends in large part on the assumption that changes over time in the comparison group are a reasonable counterfactual for what would have happened to the demonstration group. One such decision that RTI will test is the choice of comparison groups. As part of efforts to check the consistency of the impact estimates, RTI will compare the findings from the core models with estimates based on assumptions, such as different combination of States for out-of-State comparison groups and different propensity-score models, for a few States. Consistency in the estimates across models will provide more confidence in the reliability of the impact estimates.

Additional Analyses. RTI will use the Nursing Home MDS to analyze additional changes in patterns of facility-based LTSS quality and use. RTI will evaluate admission rates, acuity upon admission, and selected quality measures for both short-stay (i.e., skilled nursing facility users) and long-stay facility residents. RTI will also conduct an analysis of encounter

data coding patterns, because capitated payments to MMPs under the demonstration may be affected by changes in coding intensity during the demonstration. These analyses will examine the extent to which changes in coding intensity observed in demonstration States compare with nondemonstration States or a predemonstration period.

Because enrollment is voluntary, RTI will compare the characteristics of those who enroll with those who are eligible but do not enroll in the care model and conduct analyses to further explore demonstration effects on demonstration enrollees, acknowledging that selection bias must be taken into account in interpreting the results.

Aggregate Impact Analyses. After the final multivariate analyses have been performed for individual State evaluations, the RTI team will conduct aggregate analyses to examine changes resulting from various State demonstration design features on quality, utilization, and cost outcomes. The goal of this type of analysis is to look across States that have implemented similar design features (e.g., MFFS or capitated payment model, demonstration design, contract vs. noncontract States, Health Home SPA States) and disentangle the relative effectiveness of the demonstration design choices, whereas the individual State evaluations will estimate the impact of a chosen *set* of demonstration design choices relative to the status quo in the State.

This part of the evaluation will address several research questions—for example:

- Which demonstration model (MFFS or capitated) has achieved greater savings?
- Are there differences in key outcomes (e.g., quality, utilization, expenditure types) that can be attributed to the type of financial alignment model used?
- Do the effects achieved by alternative integrated care models occur equally fast? Or does one model (MFFS vs. capitated) achieve gains more quickly than the other?
- Does the approach to enrollment (e.g., passive enrollment) affect access to care and costs?
- How does the relative degree of care management intensity and diversity across services affect outcomes?
- Do these effects vary across subgroups of beneficiaries, such as those using LTSS?

RTI will carefully consider which States to include in these meta-analyses in order to provide thoughtful conclusions. Some States will be moving beneficiaries from MFFS to capitated approaches, some from capitated approaches to better-integrated capitated approaches. The populations eligible for the demonstration also differ across States. We will include States with similar approaches or populations in appropriate meta-analyses.

Section 6 of this report provides more detail on the current plan for how the aggregate analyses will be conducted, including how the variables will be constructed and the model equation.

Section 7—Utilization and Access to Care

The impact of these demonstrations should result in changes in service use, in annual utilization patterns, and in specific patterns of care. Of particular interest is the impact across subpopulations of Medicare-Medicaid enrollees, and whether any observed impact is short term or continuous. Research questions regarding utilization include the following:

- What is the impact of the State demonstrations on utilization patterns during the course of the demonstration?
- What is the impact on hospital and nursing facility admission rates, potentially avoidable hospitalization utilization rates by setting, and on LTSS utilization rates? What is the impact of the demonstration on hospital and nursing facility length of stay?
- Do demonstrations change the balance between HCBS and nursing facility use, the types of Medicare-Medicaid enrollees who use these services, and utilization rates by type of HCBS such as personal care? Do Medicare-Medicaid enrollees receive more HCBS as a result of the demonstrations?
- Is any impact short term (e.g., lasting only for 1 year before returning to predemonstration level, increasing over time, reaching a plateau after a year or 2)?
- Does the observed impact vary by health condition or other beneficiary characteristics?
- Will case management or care coordination lead to lower hospital admission rates or, if admitted, shorter lengths of stay and shorter nursing facility and home health care episodes?
- Are demonstration group members using fewer inpatient services and more ambulatory services?
- Is the impact greater for more medically complex (multiple chronic condition), high-cost (top 10 percent) enrollees?

In addition, State demonstrations are expected to improve access to services, which should be evident through changes in utilization patterns of certain services. Research questions pertaining to access to care are as follows:

- Access to medical care: Do demonstration participants experience increases in the mean number of primary care visits and increased visit rates by specialty type?
- Access to LTSS: Does acuity on admission to nursing facilities increase? Do discharge rates back to the community from nursing facilities increase? Is there an increase in the proportion of HCBS users self-directing care?
- Access to behavioral health services: Does the mental health outpatient utilization rate increase? Does the outpatient substance use disorder service utilization rate increase?

Monitoring. To monitor States' progress during the demonstration, we will calculate high-level measures for each State to identify changes in utilization over time. Examples of utilization and access to care measures are listed in ***Table ES-7***. Various inpatient and

emergency room measures that RTI plans to include in quarterly reports are described in more detail in Section 8. RTI will also identify a range of key utilization and access to care measures to include in quarterly, annual, and final evaluation reports. For each utilization type, these measures will usually be expressed as visits per 1,000 eligible beneficiaries and users as a percentage of the demonstration-eligible population.

Table ES-7
Examples of utilization and access to care measures for the SDRS
(see Section 4 of this report for more information on the SDRS and Section 7 for more information on utilization and access to care)

Utilization measures[1]	Access-to-care measures
■ Inpatient acute ■ Inpatient psychiatric ■ Emergency room ■ Skilled nursing facility ■ Nursing facility (long stay) ■ Outpatient (primary care) ■ Outpatient behavioral health (mental health; AOD) ■ Home health ■ State Plan personal care ■ Waiver personal care ■ Other HCBS (home health, other waiver services)	■ Number of physician visits ■ Acuity on admission to nursing facilities ■ Discharge rate back to the community from nursing facilities ■ Any outpatient utilization for severe and persistent mental health conditions ■ Any substance use disorder treatment utilization

AOD = alcohol or other drugs; HCBS = home and community-based services; SDRS = State Data Reporting System.

[1] The final set of measures will be determined based on the timing and availability of data. Utilization and access-to-care measures will be calculated by RTI using data provided by CMS.

Individual State Descriptive Analyses. For annual reports, we will measure utilization rates of Medicare- and Medicaid-covered services for each State, using unlinked data to identify the effects of State demonstrations on the type and level of service use, ranging along a continuum from facility-based care to care provided at home (***Table ES-8***). Both Medicare and Medicaid data will be used for this analysis.

RTI will calculate average utilization rates at predemonstration and at the beginning, middle, and end of each demonstration. Use rates for each State will be stratified by HCC scores, health status measures, or similar measures. We will adjust for hospitalizations in the prior year using categorical HCC scores. Statistical tests will be used to test for significant differences in use across years and between subpopulations within a State.

Table ES-8
Service categories for reporting utilization measures
(see Table 16 of this report for more information)

Service type	Medicare only	Medicaid only	Medicare and Medicaid
Inpatient	—	—	X
Emergency room	—	—	X
Skilled nursing facility	X	—	—
Nursing facility (long-term stay)	—	X	—
Other facility-based[1]	—	—	X
Outpatient[2]	—	—	X
Outpatient behavioral health (mental and substance use disorder)	—	X	—
Home health	—	—	X
HCBS (PAS, waiver services)	—	X	—
Dental	—	—	X

— = not applicable. HCBS = home and community-based services; PAS = personal assistance services.

[1] Includes long-term care hospital, rehabilitation hospital, State mental health facility stays.

[2] Includes visits to physician offices, hospital outpatient departments, rehabilitation agencies.

Impact Analyses. As discussed above, in the final year of the evaluation RTI will conduct multivariate difference–in-differences analyses to evaluate the impact of individual State demonstrations relative to their selected comparison groups (see Section 6 of this report for a detailed description of the multivariate impact analyses). Examples of outcome variables in the multivariate analyses include rates and lengths of short- and long-term nursing facility stays, number of primary care provider (PCP) visits, number of specialty physician visits, and rates and number of months of personal assistance services and HCBS waiver services. Any inpatient analyses other than rates of overall inpatient use will be discussed in the section on quality measures.

One key strategy for reducing costs without compromising quality of care is to improve care coordination by reducing fragmentation and redundancies in services. RTI will develop analyses to address this issue, such as analyzing patterns of primary versus specialty care. Measures for assessing fragmentation of care for LTSS and behavioral health services will also be explored after reviewing candidate measures.

Section 8—Quality of Care

For purposes of monitoring and conducting impact analyses, RTI has selected a set of quality measures that are largely utilization based (see ***Table ES-9***). Many of these

measures are available through claims and encounter data that RTI will obtain from CMS. RTI expects these data to be available for descriptive quarterly reporting for demonstration States, and for final impact analyses for both demonstration and comparison groups. Some measures, such as HEDIS, have standardized definitions that will allow RTI to monitor the results across all capitated demonstration States on an annual basis.

Table ES-9
Evaluation quality measures
(see Table 18 in this report for definitions and specifications for these measures)

Measure concept	State model (capitated or MFFS)
RTI team calculations based on data obtained from CMS	
30-day all-cause risk-standardized readmission rate	Capitated, MFFS
Influenza immunization	Capitated, MFFS
Pneumococcal vaccination for beneficiaries 65 and older	Capitated, MFFS
Ambulatory care sensitive condition admissions—overall composite (AHRQ PQI #90)	Capitated, MFFS
Ambulatory care sensitive condition admissions—chronic composite (AHRQ PQI #92)	Capitated, MFFS
Preventable ED visits	Capitated, MFFS
ED visits, excluding those resulting in inpatient admission or death	Capitated, MFFS
Admissions with primary diagnosis of a severe and persistent mental illness or substance use disorder	Capitated, MFFS
Follow-up after hospitalization for mental illness	Capitated, MFFS
Screening for clinical depression and follow-up	Capitated, MFFS
Cardiac rehabilitation following hospitalization for cardiac event	Capitated, MFFS
Percent of high-risk long-stay NF residents with pressure ulcers	Capitated, MFFS
Screening for fall risk	Capitated, MFFS
Initiation and engagement of alcohol and other drug dependence treatment	Capitated, MFFS
HEDIS data obtained from CMS	
Adult BMI assessment	Capitated
Annual monitoring for patients on persistent medications	Capitated
Antidepressant medication management	Capitated
Breast cancer screening	Capitated
Care transition record transmitted to health care professional	Capitated
Comprehensive diabetes care—selected components	Capitated
Controlling high blood pressure	Capitated

BH = behavioral health; BMI = body mass index; ED = emergency department; HEDIS = Healthcare Effectiveness Data and Information Set; LTSS = long-term services and supports; MFFS = managed fee for service; NF = nursing facility.

To conduct a thorough examination of quality of care, the evaluation will supplement the measures from Table ES-9 with the following:

- Additional State-specific quality measures that will be finalized within the first 6 months of each State's implementation.
- Quality of life, satisfaction, and access-to-care information derived from the evaluation as discussed in Section 3 and in Section 7.
- HEDIS measures that are required of MMPs and outlined in each State's MOU.
- Beneficiary surveys, such as HOS and CAHPS surveys, that MMPs are required to report to CMS.
- CAHPS surveys administered in MFFS States.
- Measures developed by RTI from publicly available sources, such as the Area Resource File (ARF), that define the health care environment in each beneficiary's residential area. These may reflect variation in the supply of available providers or general economic conditions that may apply to health care markets.

Monitoring. The quality measures used for quarterly monitoring will be reported for demonstration States and not comparison groups, because comparison groups will not be identified until after the end of each demonstration year. The measures will be standardized, however, across States to the extent possible and will be useful for monitoring trends over time within a State and across the demonstration.

Individual State Descriptive Analyses. Because States have developed different approaches to integration and may target specific groups or services, RTI will develop some measures unique to individual States within the first 6 months of each demonstration to supplement the core evaluation measures. RTI will also incorporate the quality measures that States and MMPs are required to report to CMS for this demonstration, and listed in each State's MOU, into the evaluation. Although these measures will not be available for comparison areas, they will provide insight into the quality of care that beneficiaries receive while in the demonstration.

Impact Analyses. RTI will use the evaluation measures that it calculates as dependent variables in multivariate regression analyses in the final evaluation report to identify factors contributing to quality outcomes. The analytic methods for quality measures will follow the same template as described in Section 6 (Analysis Overview) with some refinements. For example, the methods will need to be refined depending on whether the outcome is binary or continuous.

Section 9—Cost

The evaluation will use the same basic descriptive and regression-based techniques as outlined in Section 6 of this report (Analysis Overview) to analyze cost. It will examine how costs are associated with the variety of services that beneficiaries receive, including

medical, behavioral health, and LTSS. The research questions regarding cost analyses include the following:

- Do the demonstrations reduce costs?
- If so, how were the demonstrations able to reduce the costs of Medicare-Medicaid enrollees compared with the comparison group?
- How do the demonstrations differentially affect expenditures for beneficiaries at risk for having high costs?

Monitoring. RTI will identify high-level cost measures that can be calculated for all States to monitor changes over time. For MFFS demonstration States, RTI will provide per-capita or per-user costs for categories of services (e.g., inpatient, outpatient, long-term nursing facility, mental health) from claims to understand how costs change quarterly. For capitated demonstration States, costs to the Medicare and Medicaid programs are the PMPM rates paid to MMPs, combined with capitated or FFS costs for those who opt out or disenroll. RTI plans to include Part D PMPM and any PMPM reconciliation data provided by CMS. Accounting for all of these types of costs is important because of the cost implications of possible selection bias.

Individual State Descriptive Analyses. RTI will measure predemonstration and demonstration spending on Medicare-Medicaid enrollees for both Medicare and Medicaid, and present descriptive cost analyses in quarterly and annual reports. RTI will also present in annual reports the costs for various subpopulations, such as demographic groups, LTSS users, and beneficiaries with intellectual and developmental disabilities, ESRD, and other chronic conditions. RTI will test for differences across demonstration periods in each State.

For MFFS States, RTI will also assess costs for the service types shown in ***Table ES-10***. For capitated model States, RTI anticipates that service-level spending will not be available in the encounter data reported by MMPs, so the utilization analysis described in Section 7 will be used to understand the impact of the demonstration by type of service. Other factors, such as changes in coding intensity, could also play a role in demonstration costs, and RTI will consider such factors in its analysis.

Impact Analyses. RTI will estimate the demonstrations' impact on Medicare and Medicaid costs, using regression-based techniques to learn what factors contribute to cost savings or increases. The goals are to learn whether certain types of demonstration approaches save more money than others, or whether costs are lower in the demonstration group than the comparison group for certain subgroups. CMS is also interested in which types of services (e.g., inpatient, HCBS) contribute the most to cost differences between the demonstration and comparison groups as State demonstrations promote changes in utilization patterns through care management.

Table ES-10
Service categories and associated data sources for reporting cost in MFFS States

Service type	Encounter data (Medicare Advantage)	Medicaid only (FFS)	Medicare and Medicaid (FFS)
Inpatient	—	—	X
Emergency room	—	—	X
Nursing facility (short rehabilitation stay)	—	—	X
Nursing facility (long-term stay)	—	X	—
Other facility-based[1]	—	—	X
Outpatient[2]	—	—	X
Outpatient behavioral health (mental and substance use disorder)	—	X	—
Home health	—	—	X
HCBS (State Plan PAS, waiver services)	—	X	—
Dental	—	X	X
Prescription drug PMPM	—	—	X
Managed care PMPM	X	—	—

— = not applicable; FFS = fee for service; HCBS = home and community-based services; PAS = personal assistance services; PMPM =per member per month payments.

[1] Includes long-term care hospital, rehabilitation hospital, State mental health facility stays.

[2] Includes visits to physician offices, hospital outpatient departments, rehabilitation agencies.

In addition to cost analyses for all Medicare-Medicaid enrollees eligible for the demonstration, MFFS demonstration States should be expected to reduce total costs for high-cost beneficiaries. Demonstration and comparison group beneficiaries will be stratified to identify the groups of beneficiaries that have traditionally been the most expensive service users in the demonstration State. High-cost beneficiaries may include those with multiple comorbidities, severe and persistent mental illness (SPMI), LTSS users, or prior inpatient and/or skilled nursing facility stays. RTI also will conduct cost analyses exploring demonstration effects on demonstration enrollees, acknowledging that selection bias must be taken into account in interpreting the results.

For capitated model demonstrations, RTI will estimate cost savings accruing to the Medicare and Medicaid programs separately twice during the demonstration, using a regression-based approach and a comparison group. To determine annual total costs (overall and by payer) for these analyses, RTI will aggregate the Medicare and Medicaid PMPM payments paid to the MMPs, Medicare Advantage plans, and Medicaid managed care organizations, and the FFS costs for the eligible population that are not enrolled in the demonstration. RTI will include Part D PMPM and any PMPM reconciliation data provided by CMS in the final

assessment of cost impact to ensure that all data are available. The methodology will be reviewed and approved by the CMS Office of the Actuary. For MFFS States, savings will be calculated after each demonstration period using an actuarial methodology for performance payment purposes. This methodology has been presented to CMS in a separate memorandum. The evaluation will also use a regression-based approach to examine savings at the end of the demonstration. The assumptions underlying the two methods will be as consistent as possible.

Section 10—Subpopulations and Health Disparities

It is important to understand whether the demonstrations have differential effects on subpopulations as defined by disability type, or demographic or clinical characteristics, such as cognitive status, clinical complexity, and residence (community-residing or in a residential setting).

The overarching research questions for subpopulations are as follows: Does the demonstration have an impact on the quality of care, service utilization patterns, and the beneficiary experience for subpopulations and the costs incurred for their services, and do these effects differ from those on the overall population of Medicare-Medicaid enrollees? To answer these questions, four specific research issues will be reflected in the qualitative protocol development and the quantitative analyses:

- How do the demonstrations, as implemented by the different States, address the unique needs of the subpopulations? Are there special initiatives designed to meet the needs of these populations (e.g., special care coordination efforts, new services for people with severe and persistent mental illness, or nursing facility diversion programs)? Do the demonstration States successfully implement what they proposed? Do the models that focus on subpopulations work better than those that are designed for more general populations?
- Do the demonstrations reduce expenditures and improve beneficiary experience, quality of care, and health outcomes for subpopulations? What is the effect on service use?
- Do the demonstrations reduce or eliminate undesirable disparities (e.g., by race or ethnicity) in access to care, beneficiary experience, health care utilization, expenditures, quality of care, and health outcomes?
- To the extent that the demonstrations have positive outcomes for subpopulations, what features of the demonstration account for these outcomes?

RTI will work with CMS to identify high-priority, policy-relevant populations to analyze for each State. Possible subpopulation groups of interest include racial and ethnic groups, people living in rural or inner-city areas, younger people with disabilities, people age 65 and older, people with SPMI, people with developmental disabilities, users of LTSS, and high-cost beneficiaries.

Below are examples of how the evaluation will be targeted to beneficiaries with behavioral health conditions and individuals residing in nursing facilities.

Beneficiaries with Behavioral Health Conditions. The evaluation team will conduct subanalyses for the population of individuals with behavioral health conditions, defined to include severe and persistent mental illness and substance use disorders. These analyses will evaluate the impact of the demonstrations on quality, utilization, and access to care for medical, LTSS, and behavioral health services, and will also examine qualitative data gathered through interviews, focus groups, and surveys. Examples of the range of measures that will be examined for beneficiaries with behavioral health conditions include outpatient behavioral health services; HCBS services; new long-term nursing facility admissions for beneficiaries with SPMI; access to a full range of scheduled and urgent medical care, behavioral health services, and LTSS; beneficiary reports of improved quality of life as a result of access to the full range of services; beneficiary choice of medical, behavioral, and LTSS services and providers; beneficiary reports on satisfaction with their life; care coordination assessment processes that integrate/address health, behavioral health, and LTSS; hospitalizations for beneficiaries with SPMI; outpatient visits after hospitalization for mental illness; and initiation and engagement of alcohol and other drug dependence treatment. Results of descriptive analyses will be presented in annual reports. The final evaluation reports will include multivariate analyses.

Nursing Facility Residents. By aligning Medicare and Medicaid incentives, the demonstrations have an opportunity to improve quality of care in nursing facilities, reduce potentially avoidable hospitalizations of nursing facility residents, and, through rebalancing efforts, prevent, delay, or shorten facility stays. Conversely, if demonstration providers seek to achieve savings by negotiating lower-cost contracts with nursing facilities, lower quality of care could result. The evaluation will analyze nursing facility admission rates, acute-care utilization (e.g., physician visits, hospitalizations, emergency room use) and cost patterns for individuals receiving short-term skilled nursing facility care and for long-stay residents. In addition, we will use the Nursing Home MDS to evaluate the level of impairment or acuity of new nursing facility entrants to evaluate the extent to which the demonstrations are maintaining frail individuals in the community, and monitor selected nursing facility quality measures. We will monitor trends in nursing facility admissions and quality within the demonstration States (or regions within a State) and analyze demonstration impact in comparison with facilities in comparison States or regions, using multivariate techniques.

Section 11—Next Steps

We will present the results of our analyses in a series of deliverables, including quarterly reports to CMS and States, annual reports, and a final evaluation report for each State as well as a final aggregate evaluation report (***Table ES-11***). ***Table ES-12*** summarizes the sources of data that the evaluation team will use to monitor demonstration progress and

evaluate the outcomes of the demonstrations. It provides an overview of the data States will be asked to provide, evaluation activities in which State staff will participate, and data the evaluation team will access from CMS.

Table ES-11
Deliverable timeline for monitoring and evaluation activities

Deliverable	Timeline	Data included
State-Specific Evaluation Design Plans	Summer 2013 through 2014, on a rolling basis.	The State-specific evaluation design plans detail the application of the overall research design for each State given the characteristics of each State's demonstration.
State-Specific Initial Reports	Reporting on the first 6 months of implementation in each State.	Based on qualitative data collected through site visits, interviews, or other State reporting, these reports will provide information to CMS and each individual State about early implementation experience.
Quarterly Reports to CMS and States	Quarterly, beginning the quarter after the State-specific initial 6-month report.	These reports will include preliminary information on enrollment, disenrollment, quality, utilization, and cost measures for ongoing monitoring in each State. Initially, they will include data from the SDRS and predemonstration Medicare and Medicaid data as available. Later reports will include more information as the data become available.
Annual State-Specific and Aggregate Reports	Annually, for each of the demonstration performance periods.	These reports will summarize and update preliminary information in quarterly reports to CMS and States and provide context for the analysis. They will also include descriptive analysis of quality, utilization, and cost measures and qualitative information collected during site visits, focus groups, and telephone interviews. All beneficiaries eligible for the demonstration will be included in the annual analysis. Savings will be calculated at least twice during the demonstration for capitated model States using a regression-based methodology: once during the demonstration and once after the end of the demonstration, for the final evaluation report. Savings will also be calculated annually for MFFS States using an actuarial methodology, for performance payment purposes.
Final State-Specific Evaluation Reports and Final Aggregate Evaluation Report	After the demonstration period has ended.	The final State-specific reports and the final aggregate evaluation reports will contain multivariate analyses to provide a comprehensive understanding of the effects of the demonstration interventions on quality, utilization, and cost. The final report will also include cost-savings calculations and qualitative information collected during site visits, focus groups, and telephone interviews.

MFFS = managed fee for service; MMP = Medicare-Medicaid Plan; SDRS = State Data Reporting System.

Table ES-12
Information sources for the evaluation of the Financial Alignment Demonstrations

RTI will obtain data from:	Type of data
CMS	■ Encounter data (Medicare Advantage, Medicaid, and MMP) ■ HEDIS measures ■ Results from HOS and CAHPS surveys ■ Medicare and Medicaid fee-for-service claims ■ Medicare Part D costs and dual-eligibility status ■ Medicare Advantage Prescription Drug (MARx) data ■ Nursing Home data (MDS) ■ CMS-HCC and RXHCC risk scores ■ Demonstration quality measures that States are required to report to CMS (listed in MOUs) ■ Demonstration quality measures that health plans are required to report to CMS (listed in three-way contracts or other guidance) ■ Other administrative data as available
State	■ Detailed description of State's method for identifying eligible beneficiaries ■ File with monthly information identifying beneficiaries eligible for the demonstration (can be submitted monthly or quarterly)[1] ■ State Data Reporting System (SDRS; described in detail in Section 4 of the *Aggregate Evaluation Plan*) quarterly submissions of demonstration updates, including monthly statistics on enrollments, opt-outs, and disenrollments ■ Participation in key informant interviews and site visits conducted by RTI team ■ Results from surveys, focus groups, or other evaluation activities (e.g., EQRO reports) conducted or contracted by the State,[2] if applicable ■ Other data State thinks would benefit this evaluation, if applicable
Other sources	■ Results of focus groups conducted by RTI subcontractor (Henne Group) ■ Grievances and appeals ■ Other sources of data, as available

CAHPS = Consumer Assessment of Healthcare Providers and Systems; EQRO = external quality review organization; HCC = hierarchical condition category; HEDIS = Healthcare Effectiveness Data and Information Set; HOS = Health Outcomes Survey; MDS = Minimum Data Set; MMP = Medicare Medicaid Plan; MOU = Memorandum of Understanding; RXHCC = prescription drug hierarchical condition category.

[1] These data, which include both those enrolled and those eligible but not enrolled, will be used (in combination with other data) to identify the characteristics of the total eligible and the enrolled populations. More information is provided in Section 5 of this report.

[2] States are not required to conduct or contract for surveys or focus groups for the evaluation of this demonstration. However, if the State chooses to do so, the State can provide any results from its own independent evaluation activities for incorporation into this evaluation, as appropriate.