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

New York Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD)

Evaluation Design Plan

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MEASUREMENT, MONITORING, AND EVALUATION OF STATE DEMONSTRATIONS TO INTEGRATE CARE FOR DUAL ELIGIBLE INDIVIDUALS

NEW YORK FULLY INTEGRATED DUALS ADVANTAGE DEMONSTRATION FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (FIDA-IDD)

EVALUATION DESIGN PLAN

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Executive Summary

The New York Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) is a capitated model demonstration under the Financial Alignment Initiative for full-benefit Medicare-Medicaid enrollees aged 21 or older. Other criteria include eligibility for services administered by the Office for People With Developmental Disabilities (OPWDD); eligibility for the level of care provided by intermediate care facilities for individuals with intellectual disabilities (ICFs-IID); and residence in Bronx, King, Nassau, New York, Queens, Richmond, Rockland, Suffolk, or Westchester counties. Enrollment into FIDA-IDD is on an opt-in basis, with April 1, 2016, as the first effective date. Eligible individuals were informed in March 2016 that they may enroll into FIDA-IDD; those who choose to enroll will do so through New York's enrollment broker (Centers for Medicare & Medicaid Services [CMS], 2015, p. 9). CMS and the State of New York have established a Federal-State partnership to implement the demonstration that includes a three-way contract between CMS, the State of New York, and Partners Health Plan (PHP), the one Medicare-Medicaid Plan (MMP, or FIDA-IDD plan) participating in this demonstration (three-way contract, 2016). Medicaid State Plan services; §1115(a); the OPWDD §1915(c) waiver serving individuals with developmental disabilities; and Medicare Parts A, B, and D services and items will be offered through the FIDA-IDD plan (CMS, 2015, p. 70).

CMS contracted with RTI International to monitor the implementation of all State demonstrations under the Financial Alignment Initiative, and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and State-specific evaluations. This report describes the State-specific Evaluation Plan for the New York FIDA-IDD demonstration as of May 20, 2016. The evaluation activities may be revised if modifications are made either to the FIDA-IDD demonstration or to the activities described in the *Aggregate Evaluation Plan* (Walsh et al., 2013). 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.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with chronic medical conditions and residents residing in ICFs-IID rather than in an OPWDD-licensed group home). To achieve these goals, RTI will collect qualitative and quantitative data from New York each quarter; analyze Medicare and Medicaid enrollment and claims data; conduct site visits, beneficiary focus groups, and key informant interviews; and incorporate relevant findings from any beneficiary surveys conducted by other entities. Information from monitoring and evaluation activities will be reported in a 6-month initial implementation report to CMS and the State, quarterly monitoring reports provided to CMS and the State, annual reports, and a final evaluation report. The key research questions and data sources for each are summarized in ***Table ES-1***.

The principal focus of the evaluation will be at the demonstration level. CMS has engaged an operations support contractor to monitor fulfillment of the demonstration

requirements outlined in the Memorandum of Understanding and three-way contract, including MMP-level monitoring. RTI will integrate that information into the evaluation as appropriate.

Demonstration Implementation. Evaluation of demonstration implementation will be based on case study methods and quantitative data analysis of enrollment patterns. We will monitor progress and revisions to the demonstration, and we will identify transferable lessons from the New York FIDA-IDD demonstration through the following: document review, ongoing submissions by the State through an online State Data Reporting System (e.g., enrollment and disenrollment statistics and qualitative updates on key aspects of implementation), quarterly key informant telephone interviews, and at least two sets of site visits. We will also monitor and evaluate several demonstration design features, including progress in developing an integrated delivery system, integrated delivery system supports, care coordination/case management, benefits and services, enrollment and access to care, beneficiary engagement and protections, financing, and payment elements. ***Table 6*** in ***Section 3*** of this report lists the implementation tracking elements that we will monitor for each design feature. Examples of tracking elements include efforts to build plan and provider core competencies for serving beneficiaries with various disability types; requirements for coordination and integration of clinical, OPWDD, long-term services and supports (LTSS), and behavioral health services; documentation of coordination activities between the FIDA-IDD plan 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.

The data the evaluation team gathers about implementation will be used for within-State and aggregate analyses included in the 6-month implementation report to CMS and the State and annual reports, and will provide context for all aspects of the evaluation.

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 the FIDA-IDD demonstration, and how do they differ from the State's previous system for this population?	X	X	—	X
2) To what extent did New York implement the FIDA-IDD demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—	X
3) What impact does the FIDA-IDD demonstration have on the beneficiary experience overall 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

(continued)

Table ES-1 (continued)
Research questions and data sources

Research questions	Stakeholder interviews and site visits	Beneficiary focus groups	Claims and encounter data analysis	Demonstration statistics[1]
4) What impact does the FIDA-IDD demonstration have on cost, and is there evidence of cost savings? How long did it take to observe cost savings? How were these savings achieved?	—	—	X	—
5) What impact does the FIDA-IDD demonstration have on utilization patterns in acute, long-term,[2] and behavioral health services, overall and for beneficiary subgroups?	X	X	X	X
6) What impact does the FIDA-IDD demonstration have on health care quality overall and for beneficiary subgroups?	—	—	X	X
7) Does the FIDA-IDD demonstration change access to care for medical, behavioral health, and long-term services and supports (LTSS) overall and for beneficiary subgroups? If so, how?	X	X	X	X
8) What policies, procedures, or practices implemented by New York in the FIDA-IDD demonstration can inform adaptation or replication by other States?	X	X	—	X
9) What strategies used or challenges encountered by New York in the FIDA-IDD demonstration can inform adaptation or replication by other States?	X	X	—	X

— = not applicable.

[1] Demonstration statistics refer to data that the State, CMS, or other entities will provide regarding topics including enrollments, disenrollments, grievances, appeals, and the number of Medicare-Medicaid Plans, also known as FIDA-IDD plans.

[2]These are services and supports provided in group homes, intermediate care facilities for individuals with intellectual disabilities, or nursing facilities.

Beneficiary Experience. The impact of this demonstration on beneficiary experience is a critical focus of the evaluation. Our 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 8*** in ***Section 4*** of this report aligns key elements identified in the CHCS framework with the demonstration design features listed in the demonstration implementation section. The goals of these analyses are to examine the beneficiary experience and how it varies by special population, and whether the demonstration has had the desired impact on beneficiary outcomes, including quality of life.

To understand beneficiary experience, we will monitor State and FIDA-IDD plan-reported data quarterly (e.g., reports of beneficiary engagement activities), and discuss issues related to the beneficiary experience during quarterly telephone follow-up calls and site visits with the State and with stakeholders. We will also obtain data on grievances and appeals from CMS and, as available, other sources. Focus groups will include Medicare-Medicaid enrollees from a variety of special populations or their proxies, such as people with chronic medical

conditions and residents living at home rather than in an OPWDD-licensed setting. Relevant demonstration statistics will be monitored quarterly, and quantitative and qualitative analyses of the beneficiary experience will be included in annual State-specific reports and the final evaluation report.

Analysis Overview. Quality, utilization, access to care, and cost will be monitored and evaluated using encounter, claims, and enrollment data for a 2-year predemonstration period and during the course of the demonstration. The evaluation will use an intent-to-treat (ITT) approach for the quantitative analyses, comparing the eligible population for the New York FIDA-IDD 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 area, including those who choose not to enroll, participate but then disenroll, and those who enroll but do not engage with the MMP, and a group of similar individuals in the comparison group. This approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration-eligible population. In addition, RTI will compare the characteristics of those who enroll with those who are eligible but do not enroll and conduct analyses to further explore demonstration effects on demonstration enrollees, acknowledging that selection bias must be taken into account in interpreting the results.

Identifying Demonstration and Comparison Groups. To identify the population eligible for the demonstration, New York will submit demonstration evaluation (finder) files to RTI on a quarterly basis. RTI will use this information to identify the characteristics of demonstration-eligible beneficiaries for the quantitative analysis. ***Section 4.2.2.1*** of this report provides more detail on the contents of the demonstration evaluation (finder) files.

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. Because New York does not intend to implement the demonstration statewide, RTI will consider an in-State comparison group. We will use statistical distance analysis to identify potential in-State and out-of-State comparison areas that are most similar to the demonstration areas in regard to environmental variables, including costs, care delivery arrangements, and policy affecting Medicare-Medicaid enrollees.

Once comparison areas are selected, all Medicare-Medicaid enrollees in those areas who meet the demonstration's eligibility criteria will be selected for comparison group membership based on the ITT study design. The comparison group will be refreshed annually to incorporate new entrants into the target population as new individuals become eligible for the demonstration over time. We will use propensity-score weighting to adjust for differences in individual-level characteristics between the demonstration and comparison group members, using beneficiary-level data (demographics, socioeconomic, health, and disability status) and county-level data (health care market and local economic characteristics). We will remove from the comparison group any beneficiaries with a propensity score lower than the lowest score found in the demonstration group.

The comparison areas will be determined within the first year of implementation 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.

Analyses. Analyses of quality, utilization, and cost in the New York evaluation will consist of the following:

1. A monitoring analysis to track quarterly changes in selected quality, utilization, and cost measures over the course of the New York FIDA-IDD demonstration.

2. A descriptive analysis of quality, utilization, and cost measures for annual reports with means and comparisons for subgroups of interest, including comparison group results. This analysis will focus on estimates for a broad range of quality, utilization, and cost measures, as well as changes in these measures across years or subgroups of interest within each year.

3. Multivariate difference-in-differences analyses of quality, utilization, and cost measures using a comparison group.

4. A calculation of savings twice during the demonstration. RTI is developing the methodology for evaluating savings for capitated model demonstrations, which will include an analysis of spending by program (Medicaid, Medicare Parts A and B services, Medicare Part D services).

Special Population Analyses. For the New York FIDA-IDD demonstration, people in facilities are an example of a possible special population of interest for this evaluation. For special populations, we will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and behavioral health services, and we will examine qualitative data gathered through interviews, focus groups, and surveys.

Utilization and Access to Care. Medicare, Medicaid, and PHP encounter data will be used to evaluate changes in the levels and types of services used, ranging along a continuum from institutional care to care provided at home and including changes in the percentage of enrollees receiving supports in the community or who reside in institutional settings (see ***Table 15*** of this report for more detail). We anticipate being able to develop traditional utilization measures for each of the service classes in ***Table 15*** (e.g., various inpatient use rates based on diagnoses of interest); however, as of this writing, the timing and availability of data that PHP is required to submit have not been finalized. RTI will continue to work closely with CMS to understand how the evaluation can best use these data.

Quality. Across all demonstrations, RTI will evaluate a core quality measure set for monitoring and evaluation purposes that is available through claims and encounter data. RTI will obtain these data from CMS (see ***Table 16*** of this report). We will supplement these core measures with the following:

- Additional quality measures specific to the New York FIDA-IDD demonstration that RTI may identify for the evaluation. These measures will also be available through claims and encounter data that RTI will obtain from CMS and will not require

additional State reporting. These measures will be finalized within the first year of implementation.

- Quality of life, satisfaction, and access to care information derived from the evaluation as discussed in ***Sections 4.1*** and ***4.2***.

- Healthcare Effectiveness Data and Information Set measures that the FIDA-IDD plan is required to submit, as outlined in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements (CMS, 2013).

- Beneficiary surveys, such as the Health Outcomes Survey and the Consumer Assessment of Healthcare Providers and Systems that the FIDA-IDD plan is required to report to CMS.

Cost. To determine annual total costs (overall and by payer), we will aggregate the Medicare and Medicaid per member per month payments paid to the FIDA-IDD plan and the costs for the eligible population that is not enrolled in the demonstration, per the ITT evaluation design. This approach will help us to detect overall cost impact and eliminate the effects of potential selection bias among beneficiaries who participate in the demonstration and those who disenroll. Cost savings will be calculated twice using a regression-based approach. Note that Part D costs will not be used in estimating savings, although these costs will be included in descriptive statistics as part of the evaluation. Part D costs are built into the demonstration capitation rates at the national average, so no savings are expected in these costs.

Summary of Data Sources. ***Table ES-2*** displays the sources of information the RTI evaluation team will use to monitor demonstration progress and evaluate the outcomes of the demonstrations under the Financial Alignment Initiative. The table provides an overview of the data that New York will be asked to provide and evaluation activities in which State staff will participate. As shown in this table, the RTI evaluation team will access claims, encounter, and other administrative data from CMS. These data, and how they will be used in the evaluation, are discussed in detail in this evaluation plan and in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

Table ES-2
Sources of information for the evaluation of demonstrations under the Financial Alignment Initiative

RTI will obtain data from:	Type of data
CMS	• Encounter data (Medicare Advantage, Medicaid, and the FIDA-IDD plan) • HEDIS measures • Results from the CAHPS survey and HOS • Medicare and Medicaid fee-for-service claims • Medicare Part D costs • Nursing facility data (MDS) • CMS-HCC and RXHCC risk scores • Demonstration quality measures that New York is required to report to CMS (listed in MOU) • Demonstration reporting measures that the FIDA-IDD plan is required to report to CMS (listed in the MOU, three-way contract, and other guidance) • Other administrative data as available
State	• Detailed description of the State's method for identifying eligible beneficiaries • File with monthly information identifying beneficiaries eligible for the demonstration (can be submitted quarterly)[1] • 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 the RTI team • Results from surveys, focus groups, or other evaluation activities (e.g., EQRO or Ombuds reports) conducted or contracted by the State,[2] if applicable • Other data the State believes would benefit this evaluation, if applicable
Other sources	• Results of focus groups conducted by RTI subcontractor (The 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; SDRS = State Data Reporting System.

[1] These data, which include 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 4*** 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 resulting reports from its own independent evaluation activities for incorporation into this evaluation, as appropriate.

References

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements. November 25, 2013. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf. As obtained on December 9, 2013.

Centers for Medicare & Medicaid Services (CMS) and The State of New York: Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) And New York Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees Who Have Intellectual and Developmental Disabilities, November 5, 2015. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NYMOUIDD.pdf. As obtained on February 5, 2016.

Centers for Medicare & Medicaid Services (CMS), The State of New York, and Partners Health Plan: Contract Between the United States Department of Health and Human Services In Partnership with The State of New York Department of Health and Partners Health Plan. January 14, 2016.

Walsh, E. G., Anderson, W., Greene, A. M., et al.: Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Aggregate Evaluation Plan. Contract No. HHSM500201000021i TO #3. Waltham, MA. RTI International, December 16, 2013. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html.

1. Introduction

1.1 Purpose

The Medicare-Medicaid Coordination Office (MMCO) and Innovation Center at the Centers for Medicare & Medicaid Services (CMS) have created the Financial Alignment Initiative for States to test integrated care models for Medicare-Medicaid enrollees. The goal of these demonstrations is to develop person-centered care delivery models integrating the full range of medical, behavioral health, and long-term services and supports for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

CMS contracted with RTI International to monitor the implementation of the demonstrations and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and State-specific evaluations.

This report describes the State-specific Evaluation Plan for the New York Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration as of May 20, 2016. The evaluation activities may be revised if modifications are made to either the FIDA-IDD demonstration or to the activities described in the *Aggregate Evaluation Plan* (Walsh et al., 2013). 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. This report provides an overview of the FIDA-IDD demonstration and provides detailed information on the framework for quantitative and qualitative data collection; the data sources, including data collected through RTI's State Data Reporting System (described in detail in the *Aggregate Evaluation Plan* [Walsh et al., 2013]); and impact and outcome analysis (i.e., the impact on beneficiary experience and quality, utilization, access to care, and costs) that will be tailored to the FIDA-IDD demonstration.

1.2 Research Questions

The major research questions of the FIDA-IDD evaluation are presented in ***Table 1*** with an identification of possible data sources. The evaluation will use multiple approaches and data sources to address these questions. These are described in more detail in ***Sections 3*** and ***4***.

Unless otherwise referenced, the summary of the FIDA-IDD demonstration is based on the contract between CMS, the State, and Partners Health Plan, January 14, 2016 (CMS and State of New York, 2016; hereafter, New York three-way contract, 2016); ,the Memorandum of Understanding (MOU) between the State and CMS (CMS and State of New York, 2015; hereafter MOU, 2015); the Office for People With Developmental Disabilities (OPWDD) Comprehensive Home and Community-Based Services §1915(c) waiver (CMS, 2015a, hereafter OPWDD waiver, 2015); the FIDA-IDD interdisciplinary team (IDT) policy (CMS and State of New York, 2016; hereafter, IDT policy, 2016); and discussions and e-mail communications with MMCO staff at CMS as of January 14, 2016. The details of the evaluation design are covered in the three major sections that follow:

- An overview of the FIDA-IDD demonstration
- Demonstration implementation, evaluation, and monitoring
- Impact and outcome evaluation and monitoring

Table 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 the FIDA-IDD demonstration, and how do they differ from the State's previous system for this population?	X	X	—	X
2) To what extent did New York implement the FIDA-IDD demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—	X
3) What impact does the FIDA-IDD demonstration have on the beneficiary experience overall 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 does the FIDA-IDD demonstration have on cost and is there evidence of cost savings? How long did it take to observe cost savings? How were these savings achieved?	—	—	X	—
5) What impact does the FIDA-IDD demonstration have on utilization patterns in acute, long-term,[2] and behavioral health services, overall and for beneficiary subgroups?	X	X	X	X
6) What impact does the FIDA-IDD demonstration have on health care quality overall and for beneficiary subgroups?	—	—	X	X
7) Does the FIDA-IDD demonstration change access to care for medical, behavioral health, and long-term services and supports (LTSS) overall and for beneficiary subgroups? If so, how?	X	X	X	X
8) What policies, procedures, or practices implemented by New York in the FIDA-IDD demonstration can inform adaptation or replication by other States?	X	X	—	X
9) What strategies used or challenges encountered by New York in the FIDA-IDD demonstration can inform adaptation or replication by other States?	X	X	—	X

— = not applicable.

[1] Demonstration statistics refer to data that the State, CMS, or other entities will provide regarding topics including enrollments, disenrollments, grievances, appeals, and the number of Medicare-Medicaid Plans, also known as FIDA-IDD plans.

[2] These are services and supports provided in group homes, intermediate care facilities for individuals with intellectual disabilities, or nursing facilities.

2. New York FIDA-IDD Demonstration

2.1 Demonstration Goals

The goals of the New York Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration are to improve the participant experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost-shifting between Medicare and Medicaid, and achieve cost-savings for the State and the Federal government through improvements in care and coordination (Memorandum of Understanding [MOU], 2015, p. 4).

2.2 Summary of Demonstration

FIDA-IDD is a capitated model demonstration under the Financial Alignment Initiative for full-benefit Medicare-Medicaid enrollees, aged 21 or older. Other criteria include eligibility for services administered by the Office for People With Developmental Disabilities (OPWDD); eligibility for the level of care provided by intermediate care facilities for individuals with intellectual disabilities (ICFs-IID); and residence in Bronx, King, New York, Queens, Richmond, Rockland, Nassau, Suffolk, or Westchester counties. Among those not eligible to participate in the FIDA-IDD are people enrolled in a Section §1915(c) waiver, other than the OPWDD waiver serving individuals with developmental disabilities, and individuals residing in one of several types of institutional, residential, or treatment facilities. (For a complete list of populations that are not eligible for FIDA-IDD, see MOU, 2015, p. 8–9.)

Enrollment into FIDA-IDD is on an opt-in basis and began on April 1, 2016. Eligible individuals were informed during March 2016 that they may enroll into FIDA-IDD. People who choose to enroll do so through New York's enrollment broker (MOU, 2015, p.9). Before enrollment, a beneficiary will have received his or her Medicare benefits through a Medicare Advantage plan or through Medicare fee-for-service. If enrolled in Medicare Advantage, a beneficiary may also have elected to receive his or her Medicaid health benefits through one of New York's mainstream Medicaid managed care programs, if eligible (MOU, 2015, p.9). Otherwise, individuals who receive their Medicare services on a fee-for-service basis are excluded from New York's mainstream Medicaid managed care program. Individuals with developmental disabilities are excluded from New York's managed long-term care programs (MLTC) (MOU, 2015, p. 43).

CMS and the State of New York have established a Federal-State partnership to implement the demonstration that includes a three-way contract between CMS, the State, and Partners Health Plan (PHP), the one Medicare-Medicaid Plan (MMP) (as stated in the MOU) participating in this demonstration (three-way contract, 2016; MOU, 2015, p.3). The one participating MMP, PHP, was "approved by CMS [and] offer[s] specialized networks and care management programs designed specifically to serve adults with IDD" (MOU, 2015, p. 3). PHP is a provider-based, non-profit managed care organization serving the demonstration area (CMS, December 4, 2015; CMS, January 14, 2016). To participate in FIDA-IDD, PHP was required to achieve a final score of 70 or higher on the Model of Care section of its application to participate in the Financial Alignment Initiative; submit an acceptable response to New York's Model of

Care requirements for use of self-directed services; and meet all of the requirements to be an MLTC plan. In addition, PHP was required to satisfactorily complete a joint CMS-State readiness review and enter into a three-way contract with CMS and OPWDD (MOU, 2015, p. 6). The readiness review evaluated PHP for its ability to process claims and enrollment information, accept and transition new participants and provide adequate access to covered services and items (three-way contract, 2016, p. 29).

Medicaid State plan services, §1115(a), OPWDD waiver, and Medicare Parts A, B, and D services and items will be offered through the FIDA-IDD plan (MOU, 2015, p. 70). The FIDA-IDD plan may offer supplemental benefits with the approval of CMS and OPWDD. As in Medicare Advantage, hospice services provided by Medicare-approved hospice providers are reimbursed directly by Medicare, and not through the FIDA-IDD plan (three-way contract, 2016, p. 263). The FIDA-IDD plan covers targeted home and community-based behavioral health services that are authorized under New York's §1115 Partnership Plan and delivered through one of New York's Health and Recovery Plans (CMS, 2015b). Demonstration-eligible beneficiaries who are receiving Section 1915(c) waiver services as an alternative to ICF-IID placement must be enrolled in the Section 1915(c) OPWDD Comprehensive Waiver. The OPWDD waiver is available to people with an intellectual disability, autism, or another developmental disability who require the level of care provided in an ICF-IID (OPWDD waiver, 2015) but who can reside safely in the community. This waiver supports individuals who live in their own home or in a family home, and provides 24/7 residential services. In addition, the OPWDD waiver covers center-based and community-based habilitation services, as well as supported employment services. The OPWDD waiver also covers an array of participant-directed services and supports that offer employer authority over services; under Consolidated Services and Supports, participants may also have budget authority to purchase direct assistance, treatment, and other supportive services. The OPWDD waiver is intended to be used in combination with natural supports and community-based resources to allow the participant to be as independent as possible.

Outside of the demonstration, two types of service coordination are currently available to demonstration-eligible individuals: Medicaid Service Coordination (MSC), which is targeted case management; and Plan of Care Support Services, which is similar to MSC, except that it is a waiver service designed for individuals who need a less intensive level of monitoring. Both services are provided almost exclusively through State contracts with nonprofit agencies. Under FIDA-IDD, service coordination or care management will be provided by a care manager employed by or under contract with the FIDA-IDD plan.

Table 2 provides a summary of the key characteristics of the New York FIDA-IDD demonstration compared with the system that currently exists for demonstration-eligible beneficiaries.

Table 2
Key features of the New York model predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Summary of covered benefits		
Medicare	Medicare Parts A, B, & D	Medicare Parts A, B, & D
Medicaid	Medicaid State plan, §1115(a) and HCBS waiver services	Medicaid State plan, §1115(a) and HCBS waiver services
Other		Supplemental benefits, with CMS and OPWDD approval
Payment method (capitated/FFS/MFFS) Medicare	FFS or capitated	Capitated
Medicaid (capitated or FFS)		
Primary/medical	FFS or capitated	Capitated
Behavioral health	FFS or capitated	Capitated
LTSS (excluding HCBS waiver services)	FFS	Capitated
HCBS waiver services	FFS	Capitated
Other (specify): supplemental benefits	N/A	Capitated
Care coordination/case management Care coordination for medical, behavioral health, or LTSS and by whom		
Care coordination/case management for HCBS waivers and by whom	MSC, who can be employed by the State or a nonprofit agency (TCM service); or for those with a lower level of need, PCSS coordinator, provided by either State or nonprofit agency (waiver covered service)	Care Manager, employed by or under contract to MMP
TCM	MSC, provided by either State or nonprofit agency	
Enrollment/assignment		
Enrollment method	N/A	Opt-in enrollment through enrollment broker
Attribution/assignment method	N/A	N/A

(continued)

Table 2 (continued)
Key features of the New York model predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Implementation		
Geographic area	N/A	Bronx, King, New York, Queens, Richmond, Rockland, Nassau, Suffolk or Westchester counties
Phase-in plan	N/A	Notice of option to enroll in March 2016, for coverage to start on April 1, 2016
Implementation date	N/A	April 1, 2016

FFS = fee for service; HCBS = home and community-based services; LTSS = long-term services and supports; MFFS = managed fee for service; MMP = Medicare-Medicaid Plan; MSC = Medicaid Service Coordinator; N/A = not applicable; OPWDD = Office for People With Developmental Disabilities; PCSS = Plan of Care Support Services; TCM = targeted case management.

[1] Information related to the Demonstration in this table is from the Memorandum of Understanding (2015); three-way contract (2016); and the OPWDD waiver (2015).

The characteristics of the population eligible to participate in the demonstration are presented in ***Table 3***.

Table 3
Characteristics of the New York FIDA-IDD demonstration-eligible population for fiscal year 2013 (July 2012–June 2013)

Characteristic	No. of beneficiaries	Percentage of eligible population
Developmental disabilities		
ICF Residents	2,901	14.8%
Residing in community HCBS Residential	8,810	45.0%
HCBS Non-Residential	5,686	29.0%
Other (if applicable)	2,182	11.1%
Total individuals potentially eligible for demonstration Medicare/Medicaid Duals, Ages 21 – 49 and 50+	19,579	100.0%

ICF = intermediate care facility, HCBS = home and community-based services.

NOTE: Beneficiary information based on January 2013 data snapshot.

SOURCE: CMS communication with the New York Office for People With Developmental Disabilities (OPWDD)

As shown in ***Table 4***, the total Medicare and Medicaid spending on Medicare-Medicaid enrollees making up the eligible population for this demonstration (i.e., those who would have been eligible to participate in the demonstration, had it been operational) was $2.17 billion in fiscal year 2013.

Table 4
Total expenditures for Medicare-Medicaid beneficiaries aged 21–49 and 50+ enrolled in the New York FIDA-IDD demonstration for fiscal year 2013

Population	Medicaid expenditures	Medicare expenditures[1, 2, 3]	Total expenditures
Eligible population	$2.07 billion	$0.10 billion	$2.17 billion

[1]Medicare expenditures reflect raw, historical CY 2011 (January 2011 – December 2011) Medicare Claims.

[2]Medicare Pharmacy claims are understated due to the fact that the Medicare data provided to Mercer did not contain Part D claims.

[3]Medicare data was not used for the purpose of developing the FIDA-IDD rates.

SOURCE: CMS communication with the New York Office for People With Developmental Disabilities (OPWDD).

2.3 Relevant Historical and Current Context

System Reform. New York OPWDD has engaged in a number of reform initiatives over the last several years that have significantly reshaped its current delivery system.

System Transformation. Under New York's §1115 Partnership Plan demonstration, between April 1, 2013 and December 31, 2014, CMS allowed New York to claim Federal financial participation to fund a range of activities related to the transformation of OPWDD services. This permission was granted contingent on New York's compliance with a transformation deliverables schedule, which was tied to transformational goals including OPWDD's participation in New York's Money Follows the Person demonstration, New York's participation in the Balancing Incentive Program, submission of a §1915(b)(c) waiver, expanding §1915(c) waiver slots, transitioning residents of ICFs-IID into home and community-based services (HCBS) settings, increasing the number of individuals in competitive employment, and expanding consumer directed service options (CMS, 2014).

Managed Care. The New York Department of Health, through the Office of Health Insurance Programs and its Division of Long Term Care, has considerable experience with managed care and MLTC, including partnering with CMS to implement another capitated model demonstration to integrate care for Medicare-Medicaid enrollees under the Financial Alignment Initiative. That demonstration, known as FIDA, began serving enrollees on January 1, 2015.

OPWDD plans to ultimately transition the OPWDD waiver to managed care. As part of the systems transformation goals identified under New York's §1115 Partners Plan, CMS identified a number of conditions that OPWDD must meet before moving forward with a combination §1915(b)(c) waiver. These include meeting regulatory requirements for the specialized managed care organizations that plans use for managing care (Developmental Disabilities Individual Support and Care Coordination Organizations, implementing conflict free case management, and applying an approvable rate methodology.

Standards for HCBS Settings and OPWDD's Transition Plan. According to New York's transition plan submitted to CMS in February 2015, OPWDD projects that almost 25,000 OPWDD waiver participants are residing in group homes that are considered to be in partial

compliance. OPWDD also identified another 16,000 individuals living in other residential settings that OPWDD considers to be in compliance (New York State [NYS] OPWDD, February 13, 2015). NYS is expected to resubmit its transition plan to CMS in early 2016, incorporating OPWDD's updated plan for bringing HCBS settings and services into compliance (NYS OPWDD, December 23, 2015). The MOU requires all settings and services delivered through providers opting into the FIDA-IDD provider network to comply with the HCBS rules (MOU, 2015, p. 38).

Front Door. OPWDD has implemented "Front Door" processes to create consistent, streamlined access for beneficiaries to OPWDD through each OPWDD regional office. Access involves determining eligibility for OPWDD services, selecting a case manager, identifying service needs, developing an individualized plan, applying for waiver services, and service authorization (OPWDD, Front Door Procedure Manual, pp. 11–18). The OPWDD regional office is responsible for making sure that individuals are educated about service options. As OPWDD transitions to voluntary and mandatory managed care, the regional office will also provide information about managed care (OPWDD, Front Door Procedure Manual, p. 5). However, enrollment into the FIDA-IDD demonstration will be through the enrollment broker and not through the Front Door process.

Coordinated Assessment System (CAS). OPWDD is currently validating a new CAS tool, which will be used to determine medical, developmental, habilitation, behavioral health, community-based or facility-based long-term services and supports, and social needs under the FIDA-IDD demonstration. The CAS is based on the interRAI integrated assessment suite; New York's Department of Health and the Office of Mental Health are also implementing tools from this suite (OPWDD, 2012). Until validation is complete, the existing tool (the Developmental Disabilities Planning Tool) will be used for assessments under the demonstration (MOU, 2015, p. 28). Once validated, the CAS, in conjunction with a comprehensive service planning assessment completed using the "It's All About Me" tool, will be used as the basis for developing the FIDA-IDD person-centered plan, called the Life Plan (MOU, 2015, p. 24).

Money Follows the Person (MFP). Starting in calendar year 2013, OPWDD began participating in the MFP demonstration. As of December 31, 2014, New York had transitioned 216 individuals with intellectual or developmental disabilities through its MFP program, a total of 13.7 percent of the cumulative total of 1,573 MFP transitions over the life of the program (Morris et al., 2015, Appendix A). Individuals who complete the 365 days of qualified HCBS under the MFP demonstration will transition to a §1915(c) waiver; the demonstration is expected to continue until 2020 (New York State Department of Health [NYSDOH], 2015).

Balancing Incentive Program (BIP). New York has also participated in the BIP for the period of April 1, 2013, through September 30, 2015. New York's work plan for BIP indicated that OPWDD would be working with other State agencies to implement No Wrong Door access (for OPWDD, the Front Door referenced above), implement its core standardized assessment (CAS, also referenced above), and address any conflict of interest generated when State staff delegate responsibility for determining eligibility and performing functional assessments to providers downstream. New York has used some BIP funds to provide bridge funding for fiscal intermediaries coming into compliance with the U.S. Department of Labor's domestic service

regulations under the Fair Labor Standards Act (FLSA) (NYSDOH, Consumer Directed FLSA BIP Payment Program Alert, 2016).

Judicial and Regulatory Oversight. Since 1993, New York has been under a permanent injunction that governs services and protections for class members formerly connected with the Willowbrook State School. Willowbrook was a state-supported institution for people with intellectual disabilities. The permanent injunction defines standards for case manager qualifications, staffing ratios, and the nature and frequency of case management services (OPWDD, 2015). While the FIDA-IDD MOU and three-way contract do not specifically address the Willowbrook permanent injunction, the interdisciplinary team (IDT) policy requires case managers serving Willowbrook class members to coordinate with OPWDD to assure that case management services comply with the permanent injunction (IDT policy, 2016, p. 10).

OPWDD waiver services have also been the subject of investigations conducted by the U.S. Department of Health and Human Services, Office of the Inspector General (OIG). Separate reports have found that, among other things, New York made claims for unallowable costs including room and board costs for residential settings covered under the OPWDD waiver and supported employment services (OIG, May 2014, p. ii; OIG, September 2014, p. ii). Also, payment rates for some services provided at State-operated residences exceeded actual costs (OIG, March 2014, p. ii). Concern about rate methodology for certain OPWDD waiver services contributed to the delay in implementing the FIDA-IDD demonstration (CMS, December 4, 2015). To address these concerns, OPWDD and CMS worked closely to identify specific rate-setting methodology deficiencies and prepare a plan for remediation and rationalization. After extensive efforts, OPWDD and CMS executed comprehensive amendments in late 2015, which addressed all of the methodological concerns with the OPWDD rates. These amended FFS rates serve as the base rates for the capitated rate setting methodology under the FIDA-IDD demonstration.

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3. Demonstration Implementation Evaluation

3.1 Purpose

The evaluation of the implementation process is designed to answer the following overarching questions about the New York Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD):

- What are the primary design features of the FIDA-IDD demonstration, and how do they differ from the State's previous system available to the demonstration eligible population?
- To what extent did New York implement the demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?
- What State policies, procedures, or practices implemented by New York can inform adaptation or replication by other States?
- Was the demonstration more easily implemented for certain subgroups?
- How have beneficiaries participated in the ongoing implementation and monitoring of the demonstration?
- What strategies used or challenges encountered by New York can inform adaptation or replication by other States?

3.2 Approach

The evaluation team will examine whether the demonstration was implemented as designed and will look at modifications to the design features that were made during implementation; any changes in the time frame or phase-in of the demonstration; and other factors that facilitated or impeded implementation. This section will discuss the following:

- Monitoring implementation of the demonstration by key demonstration design features
- Implementation tracking elements
- Progress indicators
- Data sources
- Interview questions and implementation reports

3.3 Monitoring Implementation of the Demonstration by Key Demonstration Design Features

The major design features of the FIDA-IDD demonstration are described using a common framework that RTI will apply to all of the demonstrations under the Financial Alignment Initiative as follows:

- Integrated delivery system
- Integrated delivery system supports
- Care coordination/case management
- Benefits and services
- Enrollment and access to care
- Beneficiary engagement and protections
- Financing and payment
- Payment elements

Our analysis of the implementation of the FIDA-IDD demonstration will be organized by these key demonstration design features. This framework will be used to define our areas of inquiry, structure the demonstration variables we track, organize information from our data collection sources, and outline our annual report. ***Table 5*** illustrates the key components of each design feature that we will monitor as part of the implementation evaluation. Our goal is to frame analysis at the level of policy or practice with examples of how the intended design features and their key components translate at the point of service delivery.

Table 5
Demonstration design features and key components

Design feature	Key components
Core components of integrated delivery systems (how the delivery system is organized/integrated; interrelationships among the core delivery system components)	• The FIDA-IDD plan • Primary care, including medical homes and health homes • LTSS • Behavioral health services • Developmental disability services • Integration functions that bridge delivery systems and roles of community-based organizations

(continued)

Table 5 (continued)
Demonstration design features and key components

Design feature	Key components
Integrated delivery systems supports	• Care team composition • Health IT applied throughout the demonstration (at State level, by the FIDA-IDD plan, at provider level or other) • Data (Medicare claims or encounter data) and other feedback to the FIDA-IDD plan, other providers (by the State or other entities) • Primary care practice support (e.g., coaching, learning collaboratives, training)
Care coordination/case management (by special population and/or for special services) • Medical/primary • LTSS • Behavioral health services • Integration of care coordination	• Assessment process • Service planning process • Care management targeting process • Support of care transitions across settings • Communication and hand-offs between care coordinators/case managers and providers
Benefits and services	• Scope of services/benefits • New or enhanced services • Excluded services • Service authorization process
Enrollment and access to care	• Integrated enrollment and access to care • Provider accessibility standards • Marketing/education protocols • Enrollment brokers • Beneficiary information and options counseling • Disenrollment policy • Assignment/referrals to providers, health homes, medical homes • Enrollment of eligible populations • Workforce development for worker supply and new functions
Beneficiary engagement and protections	• Policies to integrate Medicare and Medicaid grievances and appeals • Quality management systems • Ongoing methods for engaging beneficiary organizations in policy decisions and implementation • Approaches to capture beneficiary experience, such as surveys and focus groups • Beneficiary participation on governing board/committees

(continued)

Table 5 (continued)
Demonstration design features and key components

Design feature	Key components
Demonstration financing model and methods of payment to plans and providers	• Financing model: capitation • Entities to which the State is directly making payments • Innovative payment methods to the FIDA-IDD plan and/or to providers
Elements of payments to the FIDA-IDD plan and providers	• Incentives • Shared savings • Risk adjustment

IT = information technology; LTSS = long-term services and supports.

3.4 Implementation Tracking Elements

Through document review and interviews with State agency staff, we will identify and describe the delivery system for Medicare-Medicaid enrollees in the eligible population. This will enable us to identify key elements that New York intends to modify through the demonstration and measure the effects of those changes. Using a combination of case study methods, including document review, and telephone interviews, we will conduct a descriptive analysis of key features of the key FIDA-IDD demonstration.

The evaluation will analyze how New York is carrying out its implementation plan and track any changes it makes to its initial design as implementation proceeds. We will identify both planned changes that are part of the demonstration design (e.g., phasing in new populations) and operational and policy modifications New York makes based on changing circumstances. Finally, we anticipate that, in some instances, changes in the policy environment in the State will trigger alterations to the original demonstration design.

During site visit interviews and our ongoing communication with the State, we will collect detailed information on how New York has structured care coordination for beneficiaries enrolled in the demonstration. The evaluation will analyze the scope of care coordination responsibilities assigned to managed care organizations, the extent to which they conduct these functions directly or through contract, and internal structures established to promote service integration. We will also identify ways that the scope of care coordination activities conducted under the demonstration by managed care organizations compares to the State's approach in their capitated model programs serving other populations.

We will also collect data from the State to track implementation through the State Data Reporting System (SDRS). The State will submit quarterly demonstration statistics and qualitative updates through the SDRS (described in detail in the *Aggregate Evaluation Plan* [Walsh et al., 2013]). RTI will generate reports based on these data and conduct telephone calls with the State demonstration director as needed to understand the State's entries. We will make additional calls to State agency staff and key informants as needed to keep abreast of demonstration developments. We will use site visit interviews to learn more about what factors

are facilitating or impeding progress or leading to revisions in the New York demonstration implementation.

Table 6 shows the types of demonstration implementation elements we will track using State submissions to the SDRS, quarterly calls with State demonstration staff, other interviews, and site visits.

Table 6
Implementation tracking elements by demonstration design feature

Design feature	Tracking elements
Integrated delivery system	• Contract with the FIDA-IDD plan
	• Documentation of coordination activities between the FIDA-IDD plan and community-based organizations
	• New waiver authorities submitted for the demonstration and approved by CMS
	• Strategies for integrating primary care, behavioral health, and LTSS (as documented in State policies, contracts, or guidelines)
	• Recognition and payment for care/services by nontraditional workers
	• Innovative care delivery approaches adopted by the demonstration, including self-direction
Integrated delivery system supports	• Ongoing learning collaboratives of primary care providers
	• Support with dissemination and implementation of evidence-based practice guidelines (e.g., webinars for providers; topics addressed in learning collaboratives)
	• Decision-support tools provided or supported by State (e.g., practice-level *OR* FIDA-IDD plan level reporting on QIs)
	• State efforts to build FIDA-IDD plan and provider core competencies for serving beneficiaries with various types of disabilities
	• Provision of regular feedback to the FIDA-IDD plan and providers on the results of their performance measures
Care coordination	• Adoption of person-centered care coordination practices
	• State systems for collecting data on care coordination use
	• As available, care coordination activities directed to individual enrollees
	• State requirements for assessment and service planning
	• State requirements for coordination and integration of clinical, developmental disability services, LTSS, and behavioral health services
	• State requirements for care transition support, medication reconciliation, notification of hospitalizations
	• State actions to facilitate adoption of EMR and EHR
	• Use of informatics to identify high-risk beneficiaries

(continued)

Table 6 (continued)
Implementation tracking elements by demonstration design feature

Design feature	Tracking elements
Benefits and services	• Phase-in of new or enhanced benefits and methods to communicate them to enrollees and potential enrollees
	• Adoption of evidence-based practices and services (e.g., use of chronic disease self-management programs by practices, fall prevention programs, other)
Enrollment and access to care	• State efforts to provide integrated consumer information on enrollment, benefits, and choice of providers
	• Options counseling and information provided by Medicaid Service Coordinators, through OPWDD Front Door Information Sessions, and so on
	• Initiatives to increase enrollment in the demonstration
	• Strategies for expanding beneficiary access to demonstration benefits
	• Emergence of new worker categories/functions (e.g., health coaches, community care workers)
Beneficiary engagement and protections	• Strategies implemented to engage beneficiaries in oversight of the demonstration
	• Quality management strategy, roles, and responsibilities
	• Implementation of quality metrics
	• Adoption of new policies for beneficiary grievances and appeals based on demonstration experience
	• Role of the Ombuds program
Financing and payment	• Revisions to the demonstration's initial payment methodology, including risk-adjustment methodology
	• Risk-mitigation strategies
	• Performance incentive approaches
	• Value-based purchasing strategies

EHR = electronic health record; EMR = electronic medical record; LTSS = long-term services and supports; OPWDD = Office for People with Developmental Disabilities; QI = quality improvement initiative.

3.5 Progress Indicators

In addition to tracking implementation of demonstration design features, we will also track progress indicators, including growth in enrollment and disenrollment patterns, based on FIDA-IDD demonstration data. These progress indicators will be reported quarterly by New York through the SDRS, which will be the RTI evaluation team's tool for collecting and storing information and for generating standardized tables and graphs for quarterly monitoring reports for CMS and the State. The primary goals of the system are to serve as a repository for up-to-date information about the FIDA-IDD demonstration design and progress, to capture data elements on a quarterly basis, and to monitor and report on demonstration progress by individual

State demonstrations and the Financial Alignment Initiative as a whole. More detail on the SDRS can be found in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

Table 7 presents a summary of progress indicators developed to date. The list of progress indicators may be refined in consultation with CMS as needed. RTI will provide trainings and an instruction manual to assist States in using the SDRS.

Table 7
Examples of progress indicators

Indicator
Eligibility
No. of beneficiaries eligible to participate in the demonstration
Enrollment
Total no. of beneficiaries currently enrolled in the demonstration
No. of beneficiaries newly enrolled in the demonstration as of the end of the given month
Disenrollment
No. of beneficiaries who opted out (chose not to enroll) of the demonstration prior to enrollment
No. of beneficiaries who voluntarily disenrolled from the demonstration
No. of beneficiaries whose enrollment in the demonstration ended involuntarily (e.g., died, moved out of area, lost Medicaid eligibility, were incarcerated)
Demonstration service area
Specific counties or geographic areas
Specific to capitated model demonstrations
No. of three-way contracts with FIDA-IDD plans

3.6 Data Sources

The evaluation team will use a variety of data sources to assess whether the FIDA-IDD demonstration was implemented as planned; identify modifications made to the design features during implementation; document changes in the time frame or phase-in of key elements; and determine factors that facilitated implementation or presented challenges. These data sources include the following:

- **Policies and requirements for provider and plan agreements:** The evaluation team will review a wide range of State-developed documents that specify the New York approach to implementing the demonstration in order to develop a baseline profile of the current delivery system. Review of the agreements between New York and CMS, articulated through the demonstration Memorandum of Understanding, waivers, contract, and State Plan Amendments will further enhance our understanding of the New York approach.

- **Demonstration data (collected via the State Data Reporting System):** On a quarterly basis, we will collect data from New York to inform ongoing analysis and feedback to the State and CMS throughout the demonstration. Specifically, we will

collect data to track policy and operational changes and progress indicators that are mostly numeric counts of key demonstration elements presented in ***Table 7***. These demonstration data also may include specific information provided by CMS or other entities engaged in this demonstration, and incorporated into the State Data Reporting System.

- **State agency staff, advisory council participants, the FIDA-IDD plan, the Medicare Appeals Council, and others involved with FIDA-IDD implementation.** There will be at least two sets of site visits; the first one will occur within 6 months of demonstration implementation. Using two-person teams, supplemented with telephone interviews, we will obtain perspectives from key informants on progress to date, internal and external environmental changes, reasons New York took a particular course, and current successes and challenges. In addition to the site visits, and interim calls for clarification about State data submitted to the reporting system, in consultation with CMS we will develop a schedule of quarterly telephone interviews with various individuals involved in the demonstration.

  In addition to consumer advocates, as discussed in ***Section 4.1, Beneficiary Experience***, candidates for key informant interviews on demonstration implementation include the following:

  - Representatives from the Joint Advisory Council
  - Representatives from CMS–State Contract Management Team
  - Representatives from CMS who are conducting case comparisons of Medicare appeals
  - Representatives from the Medicare Appeals Council
  - Representatives from the FIDA-IDD plan
  - State officials, such as:
    - Deputy Commissioner, Office of Person Centered Supports, Office for People With Developmental Disabilities (OPWDD)
    - Director of the New York State Department of Health (NYSDOH) Division of Long-Term Care
    - State Medicaid director
    - Director, NYSDOH Financial Research and Analysis Unit
    - OPWDD waiver administrator
    - FIDA-IDD demonstration project director

  - New York State Office of Temporary and Disability Assistance
- Representatives from providers and provider associations
- Representatives from entities providing options counseling for the demonstration
- Representatives from the demonstration Ombudsman program (Independent Consumer Advocacy Network)
- Representatives from the State enrollment broker, New York Medicaid Choice (MAXIMUS).

The site visit interview protocols used in the evaluation will contain a core set of questions that allow us to conduct an aggregate evaluation, questions specific to the financial alignment model (capitated or managed fee for service), as well as a few questions that are specific to the FIDA-IDD demonstration. Questions will be tailored to the key informants in New York, the topic areas to be covered during key informant interviews will be developed once the demonstration is implemented, and the topics for discussion will be provided to the State in advance of the site visit. The site visit interview protocols with core questions are provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013), and will also be tailored for New York after the demonstration begins. In advance of the site visits, the RTI team will contact the State to help identify the appropriate individuals to interview. We will work with the State to schedule the site visit and the on-site interviews. We will develop an interview schedule that best suits the needs of the State and key informants we plan to interview.

3.7 Analytic Methods

Evaluation of the FIDA-IDD demonstration implementation will be presented in an initial report to CMS and the State covering the first 6 months of implementation, in annual State-specific evaluation reports, and integrated into annual aggregate reports comparing implementation issues and progress across similar demonstrations and across all demonstrations, as appropriate. We will collect and report quantitative data quarterly as noted in ***Table 7***, ***Examples of Progress Indicators***, through the State Data Reporting System. We will integrate these quantitative data with qualitative data we will collect through site visits and telephone interviews with State agency staff and other key informants and include these data in the annual reports and the final evaluation report. These data will provide context for interpreting the impact and outcomes related to beneficiary experience, quality, utilization, and costs, and enable us to analyze (1) the changes New York has made to the preexisting delivery systems serving Medicare-Medicaid enrollees, (2) challenges New York has met, and (3) approaches that can inform adaptation or replication by other States.

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4. Impact and Outcomes

4.1 Beneficiary Experience

4.1.1 Overview and Purpose

The evaluation will assess the impact of the New York Fully Integrated Duals Advantage Demonstration for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD) demonstration on beneficiary experience. Using mixed methods (i.e., qualitative and quantitative approaches), we will monitor and evaluate the experience of beneficiaries, their families, and caregivers. Our methods will include the following:

- the beneficiary voice through focus groups and stakeholder interviews conducted by RTI;
- results of surveys that may be conducted by New York, CMS, or other entities (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]);
- FIDA-IDD demonstration data and data from other sources submitted via the State Data Reporting System (SDRS; e.g., data on enrollments, disenrollments, stakeholder engagement activities);
- claims and encounter data that RTI will obtain from CMS to analyze utilization as well as access to services and outcomes for key quality measures; and
- interviews with FIDA-IDD demonstration staff during site visits or telephone interviews with RTI.

Table 8 (described in more detail below) shows the range of topics and data sources we will use to monitor and evaluate beneficiary experience. We are interested in the perspective of the beneficiaries themselves, determining specifically the impact of the demonstration on their access to needed services, the integration and coordination of services across settings and delivery systems, provider choice, enrollee rights and protections, and the provision of person-centered care. In the process, we will identify what has changed for beneficiaries since their enrollment in the demonstration and its perceived impact on their health and well-being.

This section of the evaluation plan focuses specifically on the methods we will use to monitor and evaluate beneficiary experience such as focus groups with beneficiaries, or their proxies, and interviews with consumer and advocacy groups. We also discuss information about data we will obtain from New York through interviews and the SDRS, and results of beneficiary surveys that may be administered and analyzed independent of this evaluation by the State, CMS, or other entities.

Through beneficiary focus groups and key stakeholder interviews (i.e., consumer and advocacy group members), we also will explore whether we can identify specific demonstration features in New York that may influence replication in other States. We will also collect information from State demonstration staff and CMS or other entities that reflects the

beneficiaries' experiences (e.g., grievances and appeals, disenrollment patterns) using RTI's State Data Reporting System. ***Section 3, Demonstration Implementation Evaluation***, describes topics we will monitor and document through interviews with FIDA-IDD demonstration staff and document reviews, including consumer protections and other demonstration design features intended to enhance the beneficiary experience. Refer to ***Section 4.2*** for a discussion of the use of claims and encounter data to establish baseline information about the beneficiaries eligible for the demonstration, and how we will use these data to inform our understanding of the impact of the demonstration on access to care and health outcomes.

Specifically, we will address the following research questions in this section:

- What impact does the FIDA-IDD demonstration have on the beneficiary experience overall 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?

4.1.2 Approach

This mixed-method evaluation will combine qualitative information from focus groups and key stakeholder interviews with quantitative data related to beneficiary experience derived from the RTI SDRS and findings from surveys that may be conducted independently by New York, CMS, or other entities (e.g., CAHPS). Qualitative data will be obtained directly from a beneficiary or beneficiary representative through focus groups and interviews. To avoid potential bias or conflict of interest, we will apply a narrow definition of "representative" to include only family members, advocates, or members of organizations or committees whose purpose is to represent the interest of beneficiaries and who are not service providers or do not serve in an oversight capacity for the initiative. Although no baseline qualitative data are available, beneficiaries will be asked about their experience before the demonstration and how it may have changed during the course of the demonstration.

Our framework for evaluating beneficiary experience is influenced by work conducted by the Center for Health Care Strategies (CHCS), which identified the essential elements of integration affecting beneficiary experience, including the care process and quality of life (Lind and Gore, 2010). Its work is intended to guide the design of integrated care systems for Medicare-Medicaid enrollees and to do so in ways that strengthen the beneficiary experience in the areas defined in ***Table 8***.

Table 8 aligns key elements identified in the CHCS framework with the demonstration design features described in ***Section 3, Demonstration Implementation Evaluation***. We modified some elements of the CHCS framework to reflect that not all Medicare-Medicaid enrollees require intensive services as suggested by the original CHCS language used when describing comprehensive assessments and multidisciplinary care teams. For each key element, we identify the impact on beneficiary experience and detail the data sources that RTI will use to obtain the information.

Table 8
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	FIDA-IDD demonstration data[2]	Interviews with New York agency staff on demonstration implementation
Integrated delivery system					
Choice					
Beneficiaries have choice of medical, developmental disability, behavioral, and LTSS *services*.	X	X	X	X	X
Beneficiaries have choice of medical, developmental disability, behavioral, and LTSS *providers* within the network.	X	X	X	X	X
Beneficiaries have choice to self-direct their care.	X	X	—	X	X
Beneficiaries are empowered and supported to make informed decisions.	X	X	—	—	—
Provider network					
Beneficiaries report that providers are available to meet routine and specialized needs.	X	X	X	X	—
Beneficiaries report that developmental disability services, LTSS, and behavioral health are integrated into primary and specialty care delivery.	X	X	—	X	—
Beneficiary engagement					
Beneficiaries consistently and meaningfully have the option to participate in decisions relevant to their care.	X	X	X	X	—
There are ongoing opportunities for beneficiaries to be engaged in decisions about the design and implementation of the demonstration.	X	X	—	—	X

(continued)

Table 8 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	FIDA-IDD demonstration data[2]	Interviews with New York agency staff on demonstration implementation
Streamlined processes Beneficiaries can easily navigate the delivery system.	X	X	—	X	—
Reduced duplication of services Beneficiary burden is reduced through elimination of duplicative tests and procedures.	—	X	—	X	—
Enrollment and access to care					
Enrollment Beneficiaries have choices and assistance in understanding their enrollment options.	X	X	—	X	X
Beneficiaries report ease of disenrollment.	X	X	—	X	—
Rate of beneficiaries who opt out of enrolling/choose not to enroll into demonstration.	—	—	—	X	—
Rate of disenrollment from the demonstration, by reason.	—	—	—	X	—
Access to care Beneficiaries can access the full range of scheduled and urgent medical care, developmental disability, behavioral health services, and LTSS.	X	X	—	X	—
Beneficiaries report improved quality of life due to access to the full range of services.	X	X	X	—	—
Beneficiaries report that waiting times for routine and urgent primary and specialty care are reasonable.	X	X	—	X	—

(continued)

Table 8 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	FIDA-IDD demonstration data[2]	Interviews with New York agency staff on demonstration implementation
Health outcomes					
Beneficiary health rating	—	—	X	—	—
Quality of life					
Days free from pain	—	—	X	—	—
Beneficiaries get the social and emotional supports they need	—	X	X	—	—
Beneficiaries report that they are satisfied with their life	—	X	X	—	—
Cultural appropriateness					
Beneficiaries have access to multilingual and culturally sensitive providers.	X	X	—	X	X
Beneficiaries report that written and oral communications are easy to understand.	X	X	—	X	—
Delivery systems supports					
Data sharing and communication					
Information is available and used by beneficiaries to inform decisions.	X	X	—	—	X
Beneficiaries report that providers are knowledgeable about them and their care history.	X	X	—	X	—
Beneficiaries have adequate discharge and referral instructions.	X	X	—	X	X
Beneficiaries report that providers follow up after visits or discharge.	X	X	—	X	—
Beneficiaries understand their options to specify that personal health data not be shared.	X	X	—	X	—

(continued)

Table 8 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	FIDA-IDD demonstration data[2]	Interviews with New York agency staff on demonstration implementation
Care coordination					
Assessment of need Assessment process integrates/addresses health, developmental disability, behavioral health, and LTSS.	X	X	—	X	X
Medical providers actively participate in individual care planning.	—	X	X	—	—
Beneficiaries report active participation in the assessment process.	X	X	—	X	—
Person-centered care Care is planned and delivered in a manner reflecting a beneficiary's unique strengths, challenges, goals, and preferences.	X	X	—	X	—
Beneficiaries report that care managers have the skills and qualifications to meet their needs	—	X	X	—	—
Beneficiaries report that providers listen attentively and are responsive to their concerns.	X	X	X	X	—
Coordination of care The system facilitates timely and appropriate referrals and transitions within and across services and settings.	X	X	X	X	—
Beneficiaries have supports and resources to assist them in accessing care and self-management.	X	X	—	X	—
Beneficiaries report ease of transitions across providers and settings.	X	X	X	X	—

(continued)

Table 8 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	FIDA-IDD demonstration data[2]	Interviews with New York agency staff on demonstration implementation
Family and caregiver involvement Beneficiaries have the option to include family and/or caregivers in care planning.	X	X	—	X	—
The family or caregiver's skills, abilities, and comfort with involvement are taken into account in care planning and delivery.	X	X	—	X	—
Benefits and services					
Awareness of covered benefits Beneficiaries are aware of covered benefits.	X	X	—	X	—
Availability of enhanced benefits The demonstration covers important services to improve care outcomes that are not otherwise available through Medicaid or Medicare program.	—	—	—	X	X
Flexible benefits are available to meet the needs of beneficiaries.	—	—	—	X	X
Awareness of enhanced benefits Beneficiaries are aware of enhanced benefits and use them.	X	X	—	X	—
Beneficiary safeguards					
Beneficiary protections Beneficiaries understand their rights.	X	X	—	X	—
Beneficiaries are treated fairly, are informed of their choices, and have a strong and respected voice in decisions about their care and support services.	X	X	—	X	—

(continued)

Table 8 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	FIDA-IDD demonstration data[2]	Interviews with New York agency staff on demonstration implementation
Complaints, grievances, and appeals Beneficiaries have easy access to fair, timely, and responsive processes when problems occur.	X	X	—	X	—
Number and type of beneficiary complaints, grievance, and appeals.	—	—	—	X	—
Advocacy/member services Beneficiaries get assistance in exercising their rights and protections.	X	X	—	X	—
Finance and payment					
Provider incentives Beneficiary experience is taken into account when awarding provider and plan incentives.	X	—	—	—	X
Rate of change of PCP requests (if available).	—	—	—	X	—

— = no data for cell; LTSS = long-term services and supports; PCP = primary care provider.

[1] The evaluation team has recommended questions that will be added to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, which Medicare-Medicaid Plans are required to conduct annually.

[2] Drawn from State Data Reporting System, RTI analysis of administrative data, CAHPS, or Health Outcomes Survey (HOS) results, or from other beneficiary surveys that may be conducted by the State or other entities.

As shown in ***Table 8***, we will solicit direct feedback from beneficiaries served through the demonstration to determine how closely their experience compares to the desired outcomes (improvements in personal health outcomes, quality of life, how beneficiaries seek care, choice of care options, and how care is delivered). We will include topics specific to the demonstration and supplement our understanding of direct beneficiary experience with key stakeholder interviews (e.g., consumer and advocacy groups), a review of enrollment and disenrollment, grievances and appeals, claims and encounter data analysis, and interviews with New York staff on demonstration implementation.

Table 9 highlights some of the quantitative measures of beneficiary experience we will monitor and evaluate using demonstration statistics and claims or encounter data analysis. See ***Section 4.2*** for a discussion of the quality, utilization, and access to care measures we plan to examine as part of the overall evaluation of impact of the FIDA-IDD demonstration on beneficiary outcomes, including for special populations. The draft focus group protocol and the draft stakeholder interview protocol are both discussed in this section and are available in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

We will analyze our findings by special population. When we can recruit sufficient numbers of individuals from the special populations of interest to participate in the focus groups, we will also analyze our focus group findings about beneficiary experience to determine whether differences exist by special population.

Table 9
Demonstration statistics on quality, utilization, and access to care measures of beneficiary experience

Rate of disenrollment from the demonstration by reason[1]
Number and type of beneficiary complaints, grievance, and appeals
Use of preventive services[1]
Nursing facility admissions and readmissions[1]
Use of intermediate care facilities for individuals with intellectual disabilities
Emergency room use[1]
Hospital admission and readmission rates[1]
Follow-up care after hospital discharge[1]

[1] See ***Section 4.2*** for discussion of specific measures.

4.1.3 Data Sources

We will rely on five major data sources to assess beneficiary experience as shown in ***Table 8***. In this section we describe our plan for using focus group and stakeholder interviews; results of beneficiary surveys planned by the State, CMS, or other entities (e.g., CAHPS); State demonstration data entered into the SDRS; and interviews with State demonstration staff.

4.1.3.1 Focus Groups

We will conduct at least four focus groups in New York to gain insight into how the initiative affects beneficiaries. To ensure that we capture the direct experience and observations

of those served by the FIDA-IDD demonstration, focus groups will be limited to demonstration enrollees, their family members, and informal caregivers. ***Table 10*** shows our current plan for the composition and number of focus groups.

We are aware that New York plans to engage an evaluator who may conduct its own focus groups during demonstration implementation. If New York should decide to conduct focus groups, we will use New York's findings to inform the content of our focus groups. Preliminary topics of the focus groups include beneficiaries' understanding of the demonstration, rights, options, and choices (e.g., plan, primary care provider); reasons beneficiaries choose to enroll and disenroll; their benefits; concerns or problems encountered; experience with care coordination; and access to primary and specialty care. Timing for conducting the focus groups will be influenced by our assessment of whether there is more to be learned about the experience of beneficiaries shortly after initial enrollment into the New York FIDA-IDD demonstration versus their perceptions of its effectiveness later in the FIDA-IDD demonstration. If the latter, we will conduct focus groups at least 9 months after implementation so that beneficiaries have had a substantial amount of experience with the demonstration. We will make the decision regarding timing of the focus groups in conjunction with CMS.

Table 10
Purpose and scope of State focus groups

Primary purpose	To understand beneficiary experience with the demonstration and, where possible, to identify factors and design features contributing to their experience.
Composition	Each focus group includes 8–10 individuals who may be beneficiaries or family members or caregivers representing beneficiaries. These may include but are not limited to beneficiaries: • Living in different types of settings (e.g., private home, group settings) • At different life stages (e.g., younger adults transitioning into adulthood and older adults who may be less likely to have family supports)
Number	At least four focus groups

We will recruit focus group participants from eligibility and enrollment files independent of input from the State. In doing so, we will identify beneficiaries reflecting a range of eligibility, clinical, and demographic characteristics enrolled in the FIDA-IDD demonstration. Our subcontractor, the Henne Group, will use a structured approach for screening potential participants and obtaining their agreement to participate. If there appear to be high rates of opting out or disenrollment from the demonstration in New York, we will consider convening focus groups with beneficiaries who have chosen to opt out or disenroll to understand their decisions. We will work closely with FIDA-IDD demonstration State staff to make the process for recruiting focus group members as smooth as possible for beneficiaries, such as selecting an accessible site and ensuring transportation and any needed special accommodations and supports to allow for full participation. Focus group recruitment and all focus group arrangements will be conducted with an awareness of the special populations of concern in New York. We will investigate the prevalence of non-English–speaking beneficiaries in the eligible population, and determine whether to hold any of the focus groups in languages other than English. A

preliminary focus group protocol is presented in the *Aggregate Evaluation Plan* (Walsh et al., 2013). The protocol may be modified based on final decisions about focus group composition, content, and our understanding of issues raised during implementation of the FIDA-IDD demonstration.

4.1.3.2 Key Stakeholder Interviews

Our evaluation team will conduct key stakeholder interviews (consumer and advocacy groups) in New York, either in person as part of a scheduled site visit or by telephone, with major beneficiary groups whose stakeholders are served by the FIDA-IDD demonstration. The purpose of these interviews will be to assess the level of beneficiary engagement and experience with the demonstration and its perceived impact on beneficiary outcomes. Although we will interview service providers as part of our implementation analyses, service provider perspectives will not be the source of information for assessing beneficiary experience.

Table 11 identifies potential groups in New York whose representatives we may wish to interview and the overall purpose of the interview. We will finalize the list of key stakeholders following discussions with demonstration staff in New York, a review of events and issues raised during the development and early implementation of the demonstration, and the composition of enrollment by special populations.

Table 11
Preliminary interviewees and scope of key stakeholder interviews

Primary purpose	**Baseline:** Assess understanding of and satisfaction with demonstration design; expectations for the demonstration; perceived concerns and opportunities. **Throughout demonstration:** Spot improvements and issues as they emerge and assess factors facilitating and impeding positive beneficiary experience. **Final year:** Assess extent to which expectations were met; major successes and challenges; lessons learned from beneficiary's perspective.
Special populations	Interviews will be held with consumer and advocacy groups whose members are served by the FIDA-IDD demonstration. These may include the following: • Advocacy and consumer organizations representing the demonstration's eligible populations • Advocacy and consumer organizations participating in New York's Medicaid Advisory Committee and its subcommittees • Beneficiaries serving on Partners Health Plan's Participant Advisory Committee • Beneficiary advocates
Number and frequency	**Baseline:** Up to eight telephone interviews within the first year of implementation. **Throughout demonstration:** Up to eight telephone or in-person interviews in New York each year to be conducted with the same individuals each time, unless other stakeholders or topics of interest are identified. **Final year:** Up to eight telephone or in-person interviews.

A draft outline of the key stakeholder interview at baseline is presented in the *Aggregate Evaluation Plan* (Walsh et al., 2013). We will revise this draft as we obtain more information

about the FIDA-IDD demonstration and the issues that arise during its planning/design phase and early implementation.

4.1.3.3 Beneficiary Surveys

The RTI evaluation team will not directly administer any beneficiary surveys as part of the evaluation, and we are not requiring that States administer beneficiary surveys for purposes of the evaluation. We will include relevant findings from beneficiary surveys already being conducted for this demonstration by New York, CMS, or other entities.

As part of CMS requirements for capitated model plans, the FIDA-IDD plan will be required to conduct the Health Outcomes Survey (HOS) and CAHPS. The Medicare HOS and CAHPS surveys will be sampled at the demonstration plan level, allowing cross-plan and aggregate comparisons, where appropriate. RTI has recommended standard questions for inclusion in CAHPS surveys across all demonstrations under the Financial Alignment Initiative. Topics on which we will recommend common questions across State demonstrations are shown in ***Table 8***.

4.1.3.4 Demonstration Data

We will use data about the demonstration that we collect from New York during site visits, from reports and other materials developed by the State, through the SDRS, and data obtained from CMS or other entities to assess the beneficiary experience. Data of particular interest include the following:

- Complaint, appeal, and grievance data from CMS or other entities, as available.
- Disenrollment and opt-out rates.
- 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.
- Rate of change in primary care provider assignment (if available).

The above quantitative indirect measures will be collected for all Medicare-Medicaid enrollees served under the demonstration and will be analyzed by special populations.

In addition, New York plans to monitor quality using a selection of State-specified measures. To the extent relevant, we will use findings from these State-specific metrics to augment our assessment of beneficiary experience and outcomes in New York.

4.1.3.5 Interviews with FIDA-IDD Demonstration Staff

In addition to key stakeholder interviews conducted with consumer and advocacy groups, we will address issues of beneficiary engagement and feedback during our interviews with FIDA-IDD demonstration staff. These interviews, described in ***Section 3***, will provide another perspective on how New York communicates and works with beneficiaries during demonstration design and implementation.

4.1.4 Analytic Methods

Our analysis will assess beneficiary experience and determine, where possible, how it is affected by financial model and demonstration design features. We also want to examine whether and how beneficiary experience varies by special population. The Henne Group will audio-record all focus groups, subject to approval of the group members, and the audio-recordings will be transcribed. Key stakeholder interview and focus group transcripts will be imported and analyzed using QSR NVivo 9, qualitative data analysis software, to identify emergent themes and patterns regarding beneficiary experiences during the demonstration and issues related to the evaluation research questions. A structured approach to qualitative analysis in NVivo 9 will allow us to identify themes in New York and compare and contrast those themes by special population within and across States. Because New York is implementing a capitated model demonstration, we are particularly interested in comparing findings from New York with those of capitated model demonstrations in other States, and in determining whether particular design features in this demonstration are likely to affect beneficiary experience.

Most demonstration data will be collected and tracked through the State Data Reporting System. We will also request summary statistics and reports from New York and summaries of the required Participant Feedback Sessions and Participant Advisory Committee meetings conducted by the FIDA-IDD plan. Information from site visits and site-reported data beyond those described specifically in this section also are expected to inform analysis of beneficiary experience research questions. The findings will be grouped into the beneficiary experience domains defined in ***Section 4.1.2***.

The evaluation will consider indications of pre-demonstration beneficiary experience that may be available from other sources. The evaluation will not, however, have baseline data or comparison group results in this area. Results of beneficiary surveys, focus groups, and other approaches employed during the demonstration period will be presented in the annual and final evaluation reports along with available context to inform interpretation.

4.2 Analyses of Quality, Utilization, Access to Care, and Cost

4.2.1 Purpose

This section of the report outlines the research design, data sources, analytic methods, and key outcome variables (quality, utilization, and cost measures) on which we will focus in evaluating the FIDA-IDD demonstration. These analyses will be conducted using secondary data, including Medicare and Medicaid claims and managed care encounter data. This section addresses the following research questions:

- What impact does the FIDA-IDD demonstration have on utilization patterns in acute, long-term, and behavioral health services, overall and for beneficiary subgroups?

- What impact does the FIDA-IDD demonstration have on health care quality overall and for beneficiary subgroups?

- Does the FIDA-IDD demonstration change access to care for medical, behavioral health, long-term services and supports (LTSS) overall and for beneficiary subgroups? If so, how?

- What impact does the FIDA-IDD demonstration have on cost and is there evidence of cost savings? How long did it take to observe cost savings? How were these savings achieved?

In this section, we discuss our approach to identifying the eligible population for the FIDA-IDD demonstration and for identifying comparison group beneficiaries. This section also describes the data sources, key analyses to be performed over the course of the demonstration, and the quality measures that will inform the evaluation. RTI will use both descriptive and multivariate analyses to evaluate the FIDA-IDD demonstration. Results of descriptive analyses focusing on differences across years and important subgroups on key outcome variables will be included in the New York quarterly reports to CMS and the State and in the annual reports. Multivariate analyses will be included in the final evaluation. Savings will be calculated at least twice during the demonstration: once during the demonstration and once after the demonstration period has ended.

4.2.2 Approach

An appropriate research design for the evaluation must consider whether selection is a risk for bias. Potential sources of selection bias exist in the FIDA-IDD demonstration whereby the beneficiaries choosing not to enroll in the demonstration may differ from demonstration participants. Reasons for not enrolling will vary but may be related to demonstration benefits or previous experience in managed care. To limit selection bias in the evaluation of this demonstration, we will use an intent-to-treat design. This design will address potential selection issues by including the entire population of beneficiaries eligible for the FIDA-IDD demonstration, regardless of whether they enroll or actively engage with the Partners Health Plan.

Under the intent-to-treat framework, outcome analyses will include all beneficiaries eligible for the demonstration, including those who do not enroll, participate but then disenroll, and those who enroll but do not engage with the Partners Health Plan 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. In addition, RTI will compare the characteristics of beneficiaries who enroll in the Partners Health Plan with those of beneficiaries who are eligible but do not enroll and will conduct analyses to further explore demonstration effects on demonstration enrollees, acknowledging that interpreting such results will be difficult given likely selection bias.

4.2.2.1 Identifying Demonstration Group Members

The demonstration group for the FIDA-IDD demonstration will include full-benefit Medicare-Medicaid enrollees aged 21 or older who are eligible for services administered by the Office for People With Developmental Disabilities (OPWDD); who are determined to be eligible for the level of care provided by intermediate care facilities (ICF-IID) either in such facilities or in the community through the Section 1915(c) OPWDD Comprehensive Waiver; and who reside

in the demonstration counties. The demonstration group will exclude those people who meet the exclusion criteria listed in the Memorandum of Understanding (MOU). To analyze quality, utilization, and costs in the predemonstration period, and throughout the demonstration period, New York will submit a demonstration evaluation (finder) file that includes data elements needed for RTI to correctly identify Medicare-Medicaid enrollees for linking to Medicare and Medicaid data, and information about the enrollees eligible for or enrolled in the demonstration (***Table 12***). The file will list all of the Medicare-Medicaid beneficiaries eligible for the demonstration, with additional variables in the file indicating monthly enrollment in the demonstration. Eligible individuals who were not enrolled in the demonstration in a given month will still be part of the evaluation under the intent-to-treat research design. In addition to indicating who was eligible and enrolled, this file will contain personally identifiable information for linking to Medicare and Medicaid data.

Table 12
State demonstration evaluation (finder) file data fields

Data field	Length	Format	Valid value	Description
Medicare Beneficiary Claim Account Number (Health Insurance Claim Number [HICN])	12	CHAR	Alphanumeric	The HICN. Any Railroad Retirement Board (RRB) numbers should be converted to the HICN number prior to submission to the MDM.
MSIS number	20	CHAR	Alphanumeric	MSIS identification number.
Social security number (SSN)	9	CHAR	Numeric	Individual's SSN.
Sex	1	CHAR	Alphanumeric	Sex of beneficiary (1=male or 2=female).
Person first name	30	CHAR	Alphanumeric	The first name or given name of the beneficiary.
Person last name	40	CHAR	Alphanumeric	The last name or surname of the beneficiary.
Person birth date	8	CHAR	CCYYMMDD	The date of birth (DOB) of the beneficiary.
Person ZIP code	9	CHAR	Numeric	9-digit ZIP code.
Monthly eligibility identification flag	1	CHAR	Numeric	Coded 0 if identified as not eligible for the demonstration, 1 if identified as eligible from administrative data, 2 if identified as eligible from nonadministrative data.
Monthly enrollment indicator	1	CHAR	Numeric	Each monthly enrollment flag variable would be coded 1 if enrolled and 0 if not. Quarterly demonstration evaluation (finder) files would have three such data fields.

MDM = Master Data Management; MSIS = Medicaid Statistical Information System.

4.2.2.2 Identifying a Comparison Group

The methodology described in this section reflects the plan for identifying comparison groups based on discussions between RTI and CMS and detailed in the *Aggregate Evaluation Plan* (Walsh et al., 2013). 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.

Because New York does not intend to implement statewide, RTI will consider an in-State comparison group. If we are unable to identify in-State comparison beneficiaries who are similar to the demonstration beneficiaries or if the comparison population is not sufficiently large, we will determine whether there are areas outside of New York that could be part of the comparison group.

The approach for identifying an in-State comparison area would consider three possible data sources in the following order: (1) CMS Medicaid Analytic eXtract (MAX) Person Summary File data for New York for the most recent year available to identify all OPWDD waiver beneficiaries outside the demonstration area, (2) a finder file from OPWDD of all OPWDD waiver beneficiaries outside the demonstration area with county indicators and other identifiers, or (3) availability of metropolitan statistical area (MSA)-level data on a range of measures to identify MSAs similar to the demonstration area. If MAX data do not allow us to identify relevant in-State comparison areas and beneficiaries, we would plan to discuss with OPWDD the potential for receiving a finder file of all OPWDD waiver beneficiaries outside the demonstration area. MSA-level data on needed indicators may be difficult to identify and would be the least desired possibility. We would potentially identify all OPWDD waiver beneficiaries as eligible for the comparison group.

If we found that it was not possible to have a solely in-State comparison group, we will use statistical distance analysis to identify additional potential comparison areas outside New York that are most similar to the demonstration region in regard to costs, care delivery arrangements, policy affecting Medicare-Medicaid enrollees, population density, and the supply of LTSS. The specific measures we will use for the statistical distance analysis, which would be conducted at the MSA level, are Medicare spending per Medicare-Medicaid enrollee, Medicaid spending per Medicare-Medicaid enrollee, ICF-IID users per 65-and-over Medicaid beneficiary (if available), home and community-based services users per 65-and-over Medicaid beneficiary, Personal Care users per 65-and-over Medicaid beneficiary, Medicare Advantage and Medicaid managed care penetration for full-benefit Medicare-Medicaid enrollees, Medicaid-to-Medicare physician fee ratios, population per square mile, and patient care physicians per thousand population. The three LTSS variables capture how areas differ in the settings in which they provide these services. Variation in LTSS policy is most easily visible in the population using the most LTSS (i.e., those aged 65 and over). The relative importance of institutional care observed in that population is expected to affect such use in the population under age 65 as well.

Once comparison areas are selected, all Medicare-Medicaid enrollees in those areas who meet the demonstration's eligibility criteria will be selected for comparison group membership based on the intent-to-treat study design. The comparison areas will be determined within the first year of demonstration implementation, 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 comparison group will be refreshed annually to incorporate new entrants into the eligible population as new individuals become eligible for the demonstration over time. To ensure that the comparison group is similar to the demonstration group, we will compute propensity scores and weight comparison group beneficiaries using the framework described in ***Section 4.2.2.4*** of this report.

We understand that New York has codes that RTI could use to identify potential comparison group members in New York residing outside of the demonstration areas. RTI will work with New York to determine the source data containing those codes and how we can obtain it for analysis.

4.2.2.3 Issues/Challenges in Identifying Comparison Groups

The RTI team will make every effort to account for the following four issues/challenges when identifying and creating comparison groups.

1. **Similarities between demonstration and comparison groups:** Comparison group members should be as much like demonstration group members as possible, and sufficient data are needed to identify and control for differences.
2. **Sample size:** Because an in-State comparison group is being considered, it will be important to ensure sufficient sample size for the statewide analyses and for analyses of smaller special populations. If the sample size is not sufficient, we will consider adding out-of-State comparison areas identified using the statistical distance analysis described below.
3. **Accounting for enrollment in other demonstrations:** Some Medicare-Medicaid enrollees may not be suitable for comparison group selection because of participation in other demonstrations or enrollment in Accountable Care Organizations. We will work with CMS to specify these parameters and apply them to both New York and the comparison group.
4. **Medicaid data:** Significant delays currently exist in obtaining Medicaid data. If unaddressed, this problem could result in delays in formulating appropriate comparison groups. Timeliness of Medicaid Statistical Information System (MSIS)/T-MSIS data submissions and potentially, T-MSIS transition, will need to be considered if out-of-State comparison areas are required for the evaluation.

4.2.2.4 Propensity Score Framework for Identifying Comparison Group Members

Because comparison group members may differ from the demonstration group on individual characteristics, we will compute propensity scores for the demonstration and comparison group members. The propensity score represents how well a combination of characteristics, or covariates, predicts that a beneficiary is in the demonstration group. To compute these scores for beneficiaries in the demonstration and comparison groups, we will first identify beneficiary-level and market-level characteristics to serve as covariates in the propensity-score model. Beneficiary-level characteristics may include demographics, socioeconomic, health, and disability status; and county-level characteristics may include health care market and local economic characteristics. Once the scores are computed, we will remove from the comparison group any beneficiaries with a propensity score lower than the lowest score found in the demonstration group to ensure that the comparison group is similar to the demonstration group.

The propensity scores for the comparison group will then be weighted so that the distribution of characteristics of the comparison group is similar to that of the demonstration group. By weighting comparison group members' propensity scores, the demonstration and

comparison group samples will be more balanced. More detail on this process is provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

4.2.3 Data Sources

Table 13 provides an overview of the data sources to be used in the FIDA-IDD evaluation of quality, utilization, and cost. Data sources include Medicare and Medicaid fee-for-service data, Medicare Advantage encounter data, and Medicare-Medicaid Plan encounter data. These data will be used to examine quality, utilization, and cost in the predemonstration period and during the demonstration. Data will be needed for all beneficiaries enrolled in the demonstration as well as other beneficiaries in the eligible population who do not enroll. Note that data requirements for individual beneficiaries will depend on whether they were in Medicare fee-for-service or Medicare Advantage in the predemonstration and demonstration periods.

The terms of the FIDA-IDD MOU require the State to provide timely Medicaid data through MSIS for the predemonstration and demonstration periods. Any delays in obtaining data, or delays in T-MSIS transition, may also delay portions of the evaluation.

Table 13
Data sources to be used in the New York FIDA-IDD demonstration evaluation analyses of quality, utilization, and cost

Aspect	Medicare fee-for-service data	Medicaid fee-for-service data	Encounter data[1]
Obtained from	CMS	CMS	CMS
Description and uses of data	Will be pulled from • Part A (hospitalizations) • Part B (medical services) Will be used to evaluate quality of care, utilization, and cost during the demonstration. These data will also be used for beneficiaries who opt out of (choose not to enroll in) the demonstration, have disenrolled, or do not enroll for other reasons; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups that may be in-State and/or out-of-State.	Medicaid claims and enrollment data will include data on patient characteristics, beneficiary utilization, and cost of services. Eligibility files will be used to examine changes in number and composition of Medicare-Medicaid enrollees. Will also need these data for beneficiaries who opt out of (choose not to enroll in) the demonstration, have disenrolled, or do not enroll for other reasons; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups.	Pre- and post-period beneficiary encounter data (including Medicare Advantage, and Medicare-Medicaid Plan, Medicaid-only, and Medicare Part D data) will contain information on • beneficiary characteristics and diagnoses, • provider identification/type of visit, and • beneficiary IDs (to link to Medicare and Medicaid data files). Will be used to evaluate quality (e.g., readmissions), utilization, and cost; health; access to care; and beneficiary satisfaction. Part D data will be used to evaluate cost only. These data will also be used for beneficiaries who opt out of (choose not to enroll in) the demonstration have disenrolled, or do not enroll for other reasons; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups that may be in-State and/or out-of-State.

(continued)

Table 13 (continued)
Data sources to be used in New York FIDA-IDD demonstration evaluation analyses of quality, utilization, and cost

Aspect	Medicare fee-for-service data	Medicaid fee-for-service data	Encounter data
Sources of data	Will be pulled from the following: • NCH Standard Analytic File • NCH TAP Files • Medicare enrollment data	Will be pulled from the following: • MSIS/T-MSIS (file on inpatient care, institutional, and the "other" file) • Medicaid eligibility files	Data will be collected from the following: • CMS • Medicare enrollment data
Time frame of data	Baseline file = 2 years prior to the demonstration period (NCH Standard Analytic File). Evaluation file = all demonstration years (NCH TAP Files).	Baseline file = 2 years prior to the demonstration period. Evaluation file = all demonstration years.	Baseline file = Medicare Advantage plans submit encounter data to CMS as of January 1, 2012. RTI will determine to what extent these data can be used in the baseline file. Evaluation file = Medicare Advantage and Partners Health Plan are required to submit encounter data to CMS for all demonstration years.
Potential concerns	—	Expect significant time delay for all Medicaid data.	CMS will provide the project team with data under new Medicare Advantage requirements. Any lags in data availability are unknown at this time.

— = no data; MSIS = Medicaid Statistical Information System; NCH = National Claims History; TAP = monthly Medicare claims files.

Notes on data access: CMS data contain individually identifiable data that are protected under the Health Insurance Portability and Accountability Act of 1996. CMS, however, makes data available for certain research purposes provided that specified criteria are met. RTI has obtained the necessary Data Use Agreement with CMS to use CMS data. A listing of required documentation for requesting CMS identifiable data files such as Medicare and MSIS is provided at http://www.resdac.org/cms-data/request/cms-data-request-center

The activities to identify demonstration and comparison groups and to collect and utilize claims and encounter data may be revised if modifications are made to the demonstrations or if data sources are not available as anticipated. If modifications to this evaluation plan are required, they will be documented in the annual and final evaluation reports as appropriate.

4.3 Analyses

The analyses of quantitative data on quality, utilization, and cost measures in the FIDA-IDD evaluation will consist of the following:

1. a monitoring analysis to track quarterly changes in selected quality, utilization, and cost measures over the course of the FIDA-IDD demonstration (as data are available);
2. a descriptive analysis of quality, utilization, and cost measures for annual reports with means and comparisons for subgroups of interest, including comparison group results; and
3. multivariate difference-in-differences analyses of quality, utilization, and cost measures using a comparison group.

At least one multivariate regression-based savings analysis will be calculated during the demonstration period, most likely using 2 years of demonstration data. A second savings analysis will be included in the final evaluation.

The approach to each of these analyses is outlined below in ***Table 14***, and more detail is provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013). The starting date for FIDA-IDD was April 1, 2016. and, therefore, represents a "performance period," not a calendar year. The activities for the analyses may be revised if modifications are made to the demonstrations or if data sources are not available as anticipated. If modifications to this evaluation plan are required, they will be documented in the annual and final evaluation reports as appropriate.

4.3.1 Monitoring Analysis

Data from Medicare fee for service, Partners Health Plan encounter data, MSIS files, or other data provided by New York via the SDRS will be analyzed quarterly to calculate means, counts, and proportions on selected quality, utilization, and cost measures common across States, depending on availability. Examples of measures that may be included in these quarterly reports to CMS include rates of inpatient admissions, emergency room visits, long-term nursing facility admission, cost per member per month, and all-cause hospital readmission and mortality. We will present the current value for each quarter and the predemonstration period value for each outcome to look at trends over time.

The goal of these analyses is to monitor and track changes in quality, utilization, and costs. Though quarterly analyses will not be multivariate or include comparison group data, these monitoring data will provide valuable, ongoing information on trends occurring during the demonstration period. Various inpatient and emergency room measures that can be reported are described in more detail in the section on quality measures. Some utilization measures created (for example, the proportion of people in ICF-IID facilities who enroll in the demonstration who

move to the community, and the proportion of enrollees with completed initial assessments) will be specific to the New York FIDA-IDD demonstration.

Table 14
Quantitative analyses to be performed for the New York FIDA-IDD demonstration

Aspect	Monitoring analysis	Descriptive analysis	Multivariate analyses
Purpose	Track quarterly changes in selected quality, utilization, and cost measures over the course of the demonstration.	Provide estimates of quality, utilization, and cost measures on an annual basis.	Measure changes in quality, utilization, and cost measures as a result of the demonstration.
Description of analysis	Comparison of current value and values over time to the predemonstration period for each outcome.	Comparison of the predemonstration period with each demonstration year for demonstration and comparison groups.	Difference-in-differences analyses using demonstration and comparison groups.
Reporting frequency	Quarterly to CMS and the State	Annually	Once, in the final evaluation, except for costs, which will also be calculated (at least) once prior to the final evaluation.

NOTE: The annual and final reports submitted to CMS will also include the qualitative data described earlier in this report in addition to the quantitative data outlined here.

4.3.2 Descriptive Analysis on Quality, Utilization, and Cost Measures

We will conduct a descriptive analysis of quality, utilization, and cost measures for the FIDA-IDD demonstration annually for each performance period that includes means, counts, and proportions for the demonstration and comparison groups. This analysis will focus on estimates for a broad range of quality, utilization, and cost measures, as well as changes in these measures across years or subgroups of interest within each year. The results of these analyses will be presented in the annual evaluation reports. The sections below outline the measures that will be included.

To perform this analysis, we will develop separate (unlinked) encounter, Medicare, and Medicaid beneficiary-level analytic files annually to measure quality, utilization, and cost. Though the Medicare, Medicaid, and encounter data will not be linked, the unlinked beneficiary-level files will still allow for an understanding of trends in quality, utilization, and cost measures. The analytic files will include data from the predemonstration period and for each demonstration year. Because of the longer expected time lags in the availability of Medicaid data, Medicare fee-for-service data and Partners Health Plan encounter data may be available sooner than Medicaid fee-for-service data. Therefore, we expect that the first annual report will include predemonstration Medicare and Medicaid fee-for-service data and Medicare fee-for-service, Medicare Advantage, and Partners Health Plan encounter data for the demonstration period. Medicaid fee-for-service data will be incorporated into later reports as the data become available.

Consistent with the intent-to-treat approach, all individuals eligible to participate in the demonstration will be included in the analysis, regardless of whether they disenroll, or actively

engage in the Partners Health Plan. Data will be developed for predemonstration and comparison group beneficiaries for a 2-year predemonstration period and for each of the years of the demonstration. Note that the predemonstration period data will include beneficiaries who would have been eligible for the demonstration in the predemonstration period. For those beneficiaries with shorter enrollment periods, because of beneficiary death or change of residence, for example, the analysis will weight their experience by months of enrollment within a performance period.

We will measure predemonstration and annual utilization rates and per member per month (PMPM) of Medicare- and Medicaid-covered services together, where appropriate, to look at trends in the type and level of service use during the State demonstrations. We will calculate average use rates and PMPM at predemonstration and for each demonstration period. Use rates will be stratified by hierarchical condition category (HCC) scores, which are derived from models predicting annual Medicare spending based on claim-based diagnoses in a prior year of claims where higher scores are predictive of higher spending, health status measures, or similar measures. We will adjust for hospitalizations in the prior year using categorical HCC scores or similar measures. Chi-square and *t*-tests will be used to test for significant differences in use across years and between special populations; such as Medicare-Medicaid enrollees referred for long-term care facility services.

4.3.3 Multivariate Analyses of Quality, Utilization, and Cost Measures

In the final year of the evaluation, we will use data collected for the eligible population in New York and data for the selected comparison group that will have been adjusted using propensity-score weighting methods to analyze the effect of the demonstration using a difference-in-differences method. This method uses both pre- and post-period data for both the demonstration and comparison groups to estimate effects. This method will be applied to these data for each quality, utilization, and cost outcome described in the next section for the final evaluation. The analytic approaches are described in greater detail in the *Aggregate Evaluation Plan* (Walsh et al., 2013). In addition, multivariate regression-adjusted estimates of cost effects (only) will be performed at an intermediate point of the evaluation, using data after 2 years of implementation.

4.3.4 Special Population Analyses

For those people in facilities in the FIDA-IDD demonstration, RTI will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and behavioral health services; we will also examine qualitative data gathered through interviews, focus groups, and surveys. RTI will compare the characteristics of beneficiaries who enroll with those of beneficiaries who are eligible but do not enroll 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. Descriptive analyses for annual reports will present results on selected measures stratified by special populations (e.g., those using LTSS facilities). Multivariate analyses performed for the final evaluation will account for differential effects for special populations in specification testing by using dummy variables for each of the specific special populations of interest one at a time so that the analyses can suggest whether quality, utilization, and cost are higher or lower for each of these groups.

4.4 Utilization and Access to Care

Medicare, Medicaid, and Partners Health Plan encounter data will be used to evaluate changes in the levels and types of services used, ranging along a continuum from institutional care to care provided at home (***Table 15***). Note that ***Table 15*** indicates the sources of data for these analyses during the demonstration, given that the analyses will include beneficiaries enrolled in the demonstration as well as those who are part of the population eligible for the demonstration, but do not enroll.

Table 15
Service categories and associated data sources for reporting utilization measures

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

— = not available; FFS = fee for service; HCBS = home and community-based services; MCO = managed care organization; PAS = personal assistance services.

[1] Includes stays at an intermediate care facility for individuals with intellectual disabilities, long-term care hospital, rehabilitation hospital, or State mental health facility.

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

We anticipate being able to develop traditional utilization measures for each of the service classes in ***Table 15*** (e.g., various inpatient use rates based on diagnoses of interest). RTI will continue to work closely with CMS to understand how these data can best be used by the evaluation.

4.5 Quality of Care

Across all demonstrations RTI will evaluate a core quality measure set for monitoring and evaluation purposes. Quality measures have multiple data sources: claims and encounter data, which RTI will obtain from CMS and analyze for evaluation measures listed in ***Table 16***; and information collected by New York, CMS, or others and provided in aggregate to the RTI team for inclusion in reports. The latter may include Healthcare Effectiveness Data and Information Set (HEDIS) measures collected as part of health plan performance, other data New York requires Partners Health Plan to report, and any beneficiary survey data collected by New

York, CMS, or other entities (e.g., CAHPS). CMS and New York have also identified a set of quality measures that will determine the amount of quality withhold payments (i.e., Partners Health Plan must meet quality standards to earn back a withheld portion of its capitated payments). The quality withhold measures, listed in the FIDA-IDD three-way contract, include some measures noted in this report, as well as additional measures. RTI expects to have access to the aggregated results of these additional measures and will include them in the evaluation as feasible and appropriate, understanding that these data are not available for the predemonstration period or for the comparison group.

RTI and CMS have developed the core set of evaluation measures for use across State demonstrations; the evaluation will also include a few measures specific to New York. ***Table 16*** provides a working list of the core quality measures to be included in the evaluation of the FIDA-IDD demonstration. The table specifies the measure, the source of data for the measure, whether the measure is intended to produce impact estimates, as well as a more detailed definition and specification of the numerator and denominator for the measure. These measures will be supplemented by additional evaluation measures appropriate to the FIDA-IDD demonstration. We will finalize State-specific quality measures within the first year of implementation and will obtain the needed data from CMS or other sources; New York will not need to report any additional measures.

Many of the measures in ***Table 16*** are established HEDIS measures that demonstration plans are required to report. The National Committee for Quality Assurance definitions are established and standardized. Given that these data will not be available for those who opt out or disenroll or for comparison populations, we will collect and present the results for each relevant demonstration period.

Finally, the evaluation will analyze subgroups of interest, as appropriate, and look at measures that might be particularly relevant to them (e.g., measures that might be specific to beneficiaries with intellectual or developmental disabilities). We will continue to work with CMS and the State to identify measures relevant to the FIDA-IDD demonstration and will work to develop specifications for these measures.

Table 16
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
All-cause readmission 30-day all-cause risk-standardized readmission rate	Claims/encounter RTI will acquire and analyze	Care coordination	Yes	Risk-adjusted percentage of demonstration-eligible Medicare-Medicaid enrollees who were readmitted to a hospital within 30 days following discharge from the hospital for the index admission (https://www.cms.gov/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf).	Numerator: Risk-adjusted readmissions among demonstration-eligible Medicare-Medicaid enrollees at a non-Federal, short-stay, acute-care or critical access hospital, within 30 days of discharge from the index admission included in the denominator, and excluding planned readmissions. Denominator: All hospitalizations among demonstration-eligible Medicare-Medicaid enrollees not related to medical treatment of cancer, primary psychiatric disease, or rehabilitation care, fitting of prostheses, and adjustment devices for beneficiaries at non-Federal, short-stay acute-care or critical access hospitals, where the beneficiary was continuously enrolled in Medicare and Medicaid for at least 1 month after discharge, was not discharged to another acute-care hospital, was not discharged against medical advice, and was alive upon discharge and for 30 days post-discharge.
Immunizations Influenza immunization	Claims/encounter RTI will acquire and analyze	Prevention	Yes	Percentage of demonstration-eligible Medicare-Medicaid enrollees seen for a visit between October 1 and March 31 of the 1-year measurement period who received an influenza immunization OR who reported previous receipt of an influenza immunization (https://www.cms.gov/sharedsavingsprogram/Downloads/ACO_QualityMeasures.pdf).	Numerator: Demonstration-eligible Medicare-Medicaid enrollees who have received an influenza immunization OR who reported previous receipt of influenza immunization. Denominator: Demonstration-eligible Medicare-Medicaid enrollees seen for a visit between October 1 and March 31 (flu season), with some exclusions allowed.

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Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Immunizations (cont'd) Pneumococcal vaccination for patients 65 years and older	Claims/encounter RTI will acquire and analyze	Prevention	Yes	Percentage of demonstration-eligible patients aged 65 years and older who have ever received a pneumococcal vaccine.	Numerator: Demonstration-eligible Medicare-Medicaid enrollees age 65 and over who have ever received a pneumococcal vaccination. Denominator: All demonstration-eligible Medicare-Medicaid enrollees ages 65 years and older, excluding those with documented reason for not having one.
Ambulatory care-sensitive condition admission Ambulatory care sensitive condition admissions—overall composite (AHRQ PQI # 90)	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Combination using 12 individual ACSC diagnoses for chronic and acute conditions. For technical specifications of each diagnosis, see http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx.	Numerator: Total number of acute-care hospitalizations for 12 ambulatory care-sensitive conditions among demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older. Conditions include diabetes—short-term complications; diabetes—long-term complications; COPD; hypertension; CHF; dehydration; bacterial pneumonia; UTI; angina without procedure; uncontrolled diabetes; adult asthma; lower extremity amputations among diabetics. Denominator: Demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older.
Ambulatory care-sensitive condition admissions—chronic composite (AHRQ PQI # 92)	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Combination using 9 individual ACSC diagnoses for chronic diseases. For technical specifications of each diagnosis, see http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx.	Numerator: Total number of acute-care hospitalizations for 9 ambulatory care sensitive chronic conditions among demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older. Conditions include diabetes—short-term complications; diabetes—long-term complications; COPD; hypertension; CHF; angina w/o procedure; uncontrolled diabetes; adult asthma; lower-extremity amputations among diabetics). Denominator: demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older.

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Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Admissions with primary diagnosis of a severe and persistent mental illness or substance use disorder	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of demonstration-eligible Medicare-Medicaid enrollees with a primary diagnosis of a severe and persistent mental illness or substance use disorder who are hospitalized	Numerator: Total number of acute-care hospitalizations among demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older with a primary diagnosis of a severe and persistent mental illness or substance use who are hospitalized. Denominator: Demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older.
Avoidable emergency department visits Preventable/ avoidable and primary care treatable ED visits	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Based on lists of diagnoses developed by researchers at the New York University (NYU) Center for Health and Public Service Research, this measure calculates the rate of ED use for conditions that are either preventable/avoidable, or treatable in a primary care setting (http://wagner.nyu.edu/faculty/billings/nyued-background).	Numerator: Total number of ED visits with principal diagnoses defined in the NYU algorithm among demonstration-eligible Medicare-Medicaid enrollees. Denominator: Demonstration-eligible Medicare-Medicaid enrollees.
Emergency department visits ED visits excluding those that result in death or hospital admission	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of demonstration-eligible Medicare-Medicaid enrollees with an emergency department visit.	Numerator: Total number of ED visits among demonstration-eligible Medicare-Medicaid enrollees excluding those that result in death or hospital admission. Denominator: Demonstration-eligible Medicare-Medicaid enrollees.

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Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Follow-up after mental health hospitalization Follow-up after hospitalization for mental illness	Claims/encounter RTI will acquire and analyze	Care coordination	Yes	Percentage of discharges for demonstration-eligible Medicare-Medicaid enrollees who were hospitalized for selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: (1) The percentage of members who received follow-up within 30 days of discharge; (2) The percentage of members who received follow-up within 7 days of discharge (http://www.qualityforum.org/QPS/).	Numerator: Rate 1: (Among demonstration-eligible Medicare-Medicaid enrollees) an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters, or partial hospitalizations that occur on the date of discharge; Rate 2: (Among demonstration-eligible Medicare-Medicaid enrollees) an outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters, or partial hospitalizations that occur on the date of discharge. Denominator: Demonstration-eligible Medicare-Medicaid enrollees who were discharged alive from an acute inpatient setting (including acute-care psychiatric facilities) in the measurement year. The denominator for this measure is based on discharges, not members. Include all discharges for members who have more than one discharge in the measurement year.
Fall prevention Screening for fall risk	Claims/ encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of demonstration-eligible Medicare-Medicaid enrollees aged 65 years and older who were screened for future fall risk at least once within 12 months	Numerator: Demonstration-eligible Medicare-Medicaid enrollees who were screened for future fall risk at least once within 12 months. Denominator: All demonstration-eligible Medicare-Medicaid enrollees 65 years or older.

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Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Cardiac rehabilitation (CR) Cardiac rehabilitation following hospitalization for AMI, angina CABG, PCI, CVA	Claims/encounter RTI will acquire and analyze	Care coordination	Yes	Percentage of demonstration-eligible beneficiaries evaluated in an outpatient setting who within the past 12 months have experienced AMI, CABG surgery, PCI, CVA, or cardiac transplantation, or who have CVA and have not already participated in an early outpatient CR program for the qualifying event/ diagnosis who were referred to a CR program.	Numerator: Number of demonstration-eligible Medicare-Medicaid enrollees in an outpatient practice who have had a qualifying event/diagnosis in the previous 12 months who have been referred to an outpatient cardiac rehabilitation/secondary prevention program. Denominator: Number of demonstration-eligible Medicare-Medicaid enrollees in an outpatient clinical practice who have had a qualifying cardiovascular event in the previous 12 months, who do not meet any of the exclusion criteria, and who have not participated in an outpatient cardiac rehabilitation program since the cardiovascular event.

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Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Treatment of alcohol and substance use disorders Initiation and engagement of alcohol and other drug dependence treatment	Claims/encounter RTI will acquire and analyze	Care coordination	Yes	The percentage of demonstration-eligible Medicare-Medicaid enrollees with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD treatment. The percentage who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD treatment. The percentage who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. (http://www.qualityforum.org/QPS/)	Numerator: Among demonstration-eligible Medicare-Medicaid enrollees (a) Initiation: AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis; (b) Engagement: AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. Do not count engagement encounters that include detoxification codes (including inpatient detoxification). Denominator: Demonstration-eligible Medicare-Medicaid enrollees age 13 years and older who were diagnosed with a new episode of alcohol and drug dependency during the intake period of January 1–November 15 of the measurement year. EXCLUSIONS: Exclude those who had a claim/encounter with a diagnosis of AOD during the 60 days before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service.

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Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Depression screening and follow-up Screening for clinical depression and follow-up	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of patients aged 18 and older screened for clinical depression using an age-appropriate standardized tool AND follow-up plan documented (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_eCQM_EP_June2013.zip).	Numerator: Demonstration-eligible Medicare-Medicaid enrollees whose screening for clinical depression using an age-appropriate standardized tool AND follow-up plan is documented. Denominator: All demonstration-eligible Medicare-Medicaid enrollees 18 years and older with certain exceptions (see source for the list).
Blood pressure control Controlling high blood pressure	Medical records (HEDIS EOC035)	Prevention, care coordination	No	Percentage of members aged 18–85 who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mm Hg) during the measurement year (http://www.qualityforum.org/QPS).	Numerator: Number of demonstration participants in the denominator whose most recent, representative BP is adequately controlled during the measurement year. For a member's BP to be controlled, both the systolic and diastolic BP must be <140/90mm Hg. Denominator: Demonstration participants with hypertension. A patient is considered hypertensive if there is at least one outpatient encounter with a diagnosis of HTN during the first 6 months of the measurement year.
Weight screening and follow-up Adult BMI assessment	Medical records (HEDIS EOC110)	Prevention	No	Percentage of patients aged 18–74 years of age who had an outpatient visit and who had their BMI documented during the measurement year or the year prior to measurement.	Numerator: BMI documented during the measurement year, or the year prior. Denominator: Demonstration-eligible Medicare-Medicaid enrollees 18–74 who had an outpatient visit.
Breast cancer screening	Medical records (HEDIS 0003)	Prevention	No	Percentage of women 40–69 years of age and participating in demonstration who had a mammogram to screen for breast cancer.	Numerator: Number of women 40–69 receiving mammogram in year. Denominator: Number of women 40–69 enrolled in demonstration.

(continued)

Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Antidepressant medication management	Medical records (HEDIS EOC030)	Care coordination	No	Percentage of members 18+ who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	Numerator: Two rates are reported. (1) Effective acute phase treatment—newly diagnosed and treated demonstration participants who remain on antidepressant medication for at least 84 days. (2) Effective continuation phase treatment—newly diagnosed and treated demonstration participants who remained on antidepressant medication for at least 180 days. Denominator: Newly diagnosed and treated demonstration participants over age 18.
Diabetes care Comprehensive diabetes care: selected components—HbA1c control, LDL-C control, retinal eye exam	Medical records (HEDIS EOC020)	Prevention/care coordination	No	Percentage of demonstration participants 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c control, LDL-C control, and retinal eye exam.	Numerator: Number of these who had HbA1c control or LDL-C control, or retinal eye exam in year. Denominator: Demonstration participants 18–75 with type 1 or type 2 diabetes.

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Table 16 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Medication management Annual monitoring for patients on persistent medications	Medical records (HEDIS EOC075)	Care coordination	No	Percentage who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Agents measured: (1) ACE inhibitors or ARB, (2) digoxin, (3) diuretics, (4) anticonvulsants.	Numerator: Number with at least 180 days of treatment AND a monitoring event in the measurement year. Combined rate is sum of 4 numerators divided by sum of 4 denominators. Denominator: Demonstration participants with at least 180 days of treatment in the year for a particular agent.

ACE = angiotensin-converting-enzyme; ACSC = ambulatory care-sensitive conditions; AHRQ = Agency for Healthcare Research and Quality; AMI = acute myocardial infarction; ARB = Angiotensin II receptor blockers; BMI = body mass index; BP = blood pressure; CABG = coronary artery bypass graft; CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; CVA= cerebrovascular accident; ED = emergency department; EOC = Effectiveness of Care; HbA1c = Hemoglobin A1c; HEDIS = Healthcare Effectiveness Data and Information Set; HTN = hypertension; IESD = Index Episode Start Date; LDL-C = low-density-lipoprotein cholesterol (bad cholesterol); PCI = percutaneous coronary intervention; PQI = Prevention Quality Indicator; UTI = urinary tract infection.

[1] Impact estimates will be produced only for measures where data can also be obtained for the comparison group. Measures for which data are not expected to be available in the comparison group will be tracked only within the demonstration to measures changes over time.

NOTE: Definitions, use, and specifications are as of May 20, 2016.

4.6 Cost

To determine annual total costs (overall and by payer), we will aggregate the Medicare and Medicaid PMPM payments paid to the Partners Health Plan and the costs for the eligible population that is not enrolled in the demonstration, per the intent-to-treat evaluation design. This approach will help us to detect overall cost impact and remove potential selection bias among beneficiaries who participate in the demonstration and those who opt out or disenroll. RTI will include any PMPM reconciliation data provided by CMS in the final assessment of cost impact to ensure that all data are available.

The evaluation will analyze cost data for the service types shown in ***Table 15*** in the previous section on utilization with the addition of prescription drug costs. As with quality and utilization analyses, the descriptive and impact analyses presented in the annual report will include a comparison group. We will present results for important subgroups, and in more detail to better understand their demonstration experience. We will also create a high-cost-user category and track costs of this group over time. To do this, we will measure the percentage of beneficiaries defined as high cost in Year 1 (e.g., those beneficiaries in the top 10 percent of costs). In subsequent years we will look at the percentage of beneficiaries above the Year 1 threshold to learn more about potential success in managing the costs of high-cost beneficiaries as a result of the demonstration.

We will also evaluate cost savings for capitated model demonstrations twice during the demonstration using a regression-based approach and the comparison group described in ***Section 4.2.2*** of this report. RTI will estimate cost savings accruing to the Medicare and Medicaid programs separately. Note that Part D costs will not be used in estimating savings; although these costs will be included in descriptive statistics as part of the evaluation. Part D costs are built into the demonstration capitation rates at the national average, so no savings are expected in these costs.

4.7 Analytic Challenges

Obtaining Medicaid fee-for-service data for the predemonstration and demonstration periods and Partners Health Plan encounter data for the demonstration period will be critical for the evaluation. The Medicaid Partners Health Plan encounter data are necessary to measure quality, utilization, and costs. It will be important for New York to submit Medicaid fee-for-service data in a timely manner. It will also be important for CMS to continue to work with other States that may serve as comparison groups to update and maintain their MSIS/t-MSIS submissions. RTI will continue to work closely with CMS to understand how these data can best be used by the evaluation. Other analytic challenges will include addressing financing issues including upper payment limit issues, provider taxes, and disproportionate share hospital payments as well as possible state policy changes over the course of the demonstration. RTI will work closely with CMS and the State to understand these issues and to monitor changes over the course of the demonstration and will develop approaches to incorporate these issues into analyses as necessary.

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