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

Rhode Island Draft Evaluation Design Plan

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

RHODE ISLAND DRAFT EVALUATION DESIGN PLAN VERSION 3.0

by

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Contents

List of Tables

Glossary of Rhode Island Acronyms

BHDDH	(Department of) Behavioral Healthcare, Developmental Disabilities and Hospitals	An RI State agency through which some Medicaid services are funded and managed.
CCC	Connect Care Choice	RI's primary care case management program.
CCCCP	Connect Care Choice Community Partners	An enhanced primary care case management program implemented under Phase I of the RI ICI.
CCE	Coordinating Care Entity	Under CCCCP, an organization contracted by RI that provides care coordination and service integration support to CCC practices.
CFNA	Comprehensive Functional Needs Assessment	A process performed by the MMP for enrollees receiving long-term services and supports (LTSS) and those identified as high risk, that determines risk factors, strength-based needs, and preferences, and is used to help create an ICP.
CTC-RI	Care Transformation Collaborative Rhode Island	RI's patient-centered medical home initiative.
EOHHS	Executive Office of Health and Human Services	An RI State agency responsible for managing the departments of Health; Human Services; Children, Youth and Families; and Behavioral Healthcare, Developmental Disabilities and Hospitals.
ICI	Integrated Care Initiative	An RI initiative to better integrate and manage care for Medicaid-only and dual eligible individuals. Phase I of the ICI was the creation and implementation of CCCCP and RHO; Phase II is the RI capitated model demonstration (the ICI demonstration) under the Financial Alignment Initiative.
ICM	Intensive Care Management	Care management services provided by an MMP to enrollees receiving LTSS and those identified as high risk. Services include care coordination and management provided by an LCM, an ICP, an ICT, and care transitions management.
ICP	Interdisciplinary Care Plan	A written plan of care developed for all enrollees.
ICT	Interdisciplinary Care Team	A team of professionals and others who collaborate with MMP enrollees to develop and implement an ICP.
IHS	Initial Health Screen	A telephonic assessment of enrollees living in the community, not eligible for LTSS at the time of enrollment, and not otherwise designated to be high-risk, performed by an MMP.
LCM	Lead Care Manager	An appropriately qualified professional at an MMP who is accountable for providing intensive care management services for enrollees eligible for LTSS or enrollees not eligible for LTSS and identified as high risk.
MMP	Medicare-Medicaid Plan	A health plan contracted with CMS and RI to provide integrated Medicare and Medicaid benefits.
NHPRI	Neighborhood Health Plan of Rhode Island	The MMP that will participate in the ICI Financial Alignment Demonstration. NHPRI is also the only health plan participating in the RHO program, under which it provides Medicaid benefits to Medicaid-only and Medicare-Medicaid beneficiaries.
OCP	Office of Community Programs	An RI State office that provides some individuals with LTSS care management services.

RHO	Rhody Health Options	An RI Medicaid managed care program for Medicaid-only and dual eligible individuals created under Phase I of the ICI. RHO plans provide integrated Medicaid benefits including LTSS.
RHP	Rhody Health Partners	An RI Medicaid managed care program for Medicaid-only individuals. RHP plans provide Medicaid benefits excluding LTSS.
RTH	Rhode to Home	RI's Money Follows the Person demonstration, which uses transition coordinators to provide intensive case management to older adults and individuals with disabilities in the early stages of an institution-to-community transition.

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Executive Summary

The Rhode Island demonstration under the Financial Alignment Initiative is known as the Integrated Care Initiative (ICI) demonstration. Rhode Island's Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) have contracted with a Medicare-Medicaid Plan (MMP) to provide Medicare and Medicaid services to full-benefit Medicare-Medicaid beneficiaries aged 21 or older. Individuals who reside at certain facilities or who are in hospice at the time of enrollment are not eligible to participate. Beneficiaries who enter a hospice program after enrolling in the demonstration may remain in the demonstration and continue to receive services from the MMP. Except for certain services that are specially exempted from the ICI demonstration, the MMP will be responsible for delivery and management of all medical, behavioral health, and long-term services and supports (LTSS) for its enrollees. The demonstration will be offered statewide. After a period of opt-in-only enrollment, the demonstration will initiate passive enrollment. The plan will be paid a blended, capitated rate covering Medicare and Medicaid services under a three-way contract between the MMP, the State, and CMS. The demonstration will begin with an opt-in enrollment period, with the first effective coverage date no sooner than July 1, 2016.

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 Rhode Island demonstration.The evaluation activities may be revised if modifications are made either to the Rhode Island 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 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 mental illness and/or substance use disorders and LTSS recipients). To achieve these goals, RTI will collect qualitative and quantitative data from Rhode Island 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 contracts, including MMP-level monitoring. RTI will integrate that information into the evaluation as appropriate.

Table ES-1
Research questions and data sources

Research questions	Stakeholder interviews and site visits	Beneficiary focus groups	Claims and encounter data analysis	Demonstration statistics[1]
1) What are the primary design features of the Rhode Island demonstration, and how do they differ from the State's previous system?	X	X	—	X
2) To what extent did Rhode Island implement the demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—	X
3) What impact does the Rhode Island 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 Rhode Island demonstration have on cost, and is there evidence of cost savings in the State? How long did it take to observe cost savings in the State? How were these savings achieved in the State?	—	—	X	—
5) What impact does the Rhode Island demonstration have on utilization patterns in acute, long-term, and behavioral health services, overall and for beneficiary subgroups?	X	X	X	X
6) What impact does the Rhode Island demonstration have on health care quality overall and for beneficiary subgroups?	—	—	X	X
7) Does the Rhode Island demonstration change access to care for medical, behavioral health, 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 Rhode Island in its demonstration can inform adaptation or replication by other States?	X	X	—	X
9) What strategies used or challenges encountered by Rhode Island in its 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.

Demonstration Implementation. Evaluation of demonstration implementation will be based on case study methods and quantitative data analysis of enrollment patterns. The RTI evaluation team will monitor progress and revisions to the demonstration, and will identify transferable lessons from the Rhode Island 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 provides a list of the implementation tracking elements that the RTI evaluation team will monitor for each design feature. Examples of tracking elements include State efforts to build plan and provider core competencies for serving beneficiaries with various disability types; State requirements for coordination and integration of clinical, LTSS, and behavioral health services; documentation of coordination activities between the MMP 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 the within-State and aggregate analyses that are 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.

Beneficiary Experience. The impact of this demonstration on beneficiary experience is an important focus of the evaluation. RTI's framework for evaluating beneficiary experience is influenced by work conducted by the Center for Health Care Strategies (CHCS) on the elements of integration that directly affect beneficiary experience for Medicare-Medicaid enrollees. ***Table 8*** in ***Section 4*** aligns key elements identified in the CHCS framework with the demonstration design features listed in the demonstration implementation section of this report. 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, the RTI evaluation team will monitor State-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. The team 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, such as racial, ethnic, and linguistic minorities, people with mental health conditions, substance use disorders, LTSS needs, and multiple chronic conditions. 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 Rhode Island 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 opt out, 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, Rhode Island 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 Rhode Island intends to implement its demonstration statewide, RTI will most likely identify a comparison group from out-of-State Metropolitan Statistical Areas. The RTI team will use statistical distance analysis to identify potential comparison areas that are most similar to Rhode Island in regard to costs, care delivery arrangements, and policy affecting Medicare-Medicaid enrollees.

Once a comparison State or States are selected, all Medicare-Medicaid enrollees in those States or 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 demonstration population as new individuals become eligible for the demonstration over time. The RTI team 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). The team 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 Rhode Island 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 Rhode Island 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 has developed the methodology for evaluating savings for States implementing capitated model demonstrations, which will include an analysis of spending by program (including Medicaid and Medicare Parts A and B services).

Special Population Analyses. For the Rhode Island demonstration, individuals with intellectual or developmental disabilities, individuals with severe or persistent mental illness, and individuals with LTSS needs are special populations of interest for this evaluation. For these special populations and others, the RTI team will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and behavioral health services, and will also examine qualitative data gathered through interviews, focus groups, and surveys. Descriptive analyses for annual reports will present results on selected measures stratified by special population (e.g., those using and not using behavioral health services, LTSS). Multivariate analyses performed for the final evaluation will account for differential effects for special populations to understand whether quality, utilization, and cost are higher or lower for these groups.

Utilization and Access to Care. Medicare, Medicaid, and MMP 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).

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

- Additional quality measures specific to Rhode Island 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 MMPs are required to submit, as outlined in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements (CMS, 2014).

- Beneficiary surveys, such as the Health Outcomes Survey and the Consumer Assessment of Healthcare Providers and Systems that MMPs are required to report to CMS.

Cost. To determine annual total costs (overall and by payer), the RTI team will aggregate the Medicare and Medicaid per member per month payments paid to the MMPs 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 opt out or disenroll. Cost savings will be calculated twice for capitated model demonstrations 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 Rhode Island will be asked to provide and evaluation activities in which State staff will participate. As shown in this table, the 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 MMP) ▪ HEDIS measures ▪ Results from CAHPS survey and HOS ▪ Medicare and Medicaid fee-for-service claims ▪ Medicare Part D costs[1] ▪ Nursing facility data (MDS) ▪ CMS-HCC and RXHCC risk scores ▪ Demonstration quality measures that Rhode Island is required to report to CMS (listed in the MOU) ▪ Demonstration reporting measures that health plans are required to report to CMS (listed in three-way contracts or other guidance) ▪ Other administrative data as available

(continued)

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

RTI will obtain data from:	Type of data
State	▪ Detailed description of Rhode Island's method for identifying eligible beneficiaries ▪ File with monthly information identifying beneficiaries eligible for the demonstration (can be submitted quarterly)[2] ▪ 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,[3] if applicable ▪ Other data Rhode Island believes would benefit this evaluation, if applicable
Other sources	▪ Results of focus groups conducted by RTI subcontractor (Henne Group) ▪ Grievances and appeals ▪ Other sources of data, as available

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

[1] Although Part D spending is not included in the demonstration savings calculation together with Medicaid and Medicare Parts A/B spending, the broader evaluation will analyze Part D data, including changes in Part D spending.

[2] These data, which include both those enrolled and those eligible but not enrolled, will be used (in combination with other data) to identify the characteristics of the total eligible and the enrolled populations. More information is provided in ***Section 4*** of this report.

[3] 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. October 21, 2014. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf. As obtained on October 27, 2015.

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. As obtained on January 6, 2016.

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 quality, utilization, and cost. The evaluation includes an aggregate evaluation and State-specific evaluations.

This report describes the State-specific evaluation plan for the Rhode Island demonstration. The evaluation activities may be revised if modifications are made either to the Rhode Island 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 Rhode Island 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 Rhode Island.

1.2 Research Questions

The major research questions of the Rhode Island 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*** of this report.

Unless otherwise referenced, the summary of the Rhode Island demonstration is based on the three-way contract between CMS, Rhode Island, and the Medicare-Medicaid Plan (MMP) (CMS, 2016; hereafter, Three-way contract, 2016); Memorandum of Understanding (MOU) between CMS and the Rhode Island Executive Office of Health and Human Services (EOHHS) (CMS and the State of Rhode Island, 2015; hereafter, MOU, 2015); Rhode Island's Letter of Intent #7548793 for Financial Alignment Demonstration Medicaid Integrated Care Initiative (hereafter, Letter of Intent, 2014); Rhode Island's Letter of Intent #7461250 for Coordinating Care Entity for Connect Care Choice Community Partners Program under the Medicaid Integrated Care Initiative (hereafter, Letter of Intent, 2013); and discussions and e-mail communications with MMCO staff at CMS as of August 24, 2015 (personal communication with

MMCO, August 2015). The details of the evaluation design are covered in the three major sections that follow:

- An overview of the Rhode Island 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 Rhode Island demonstration, and how do they differ from the State's previous system?	X	X	—	X
2) To what extent did Rhode Island implement the demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—	X
3) What impact does the Rhode Island 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 Rhode Island demonstration have on cost, and is there evidence of cost savings in the State? How long did it take to observe cost savings in the State? How were these savings achieved in the State?	—	—	X	—
5) What impact does the Rhode Island demonstration have on utilization patterns in acute, long-term, and behavioral health services, overall and for beneficiary subgroups?	X	X	X	X
6) What impact does the Rhode Island demonstration have on health care quality overall and for beneficiary subgroups?	—	—	X	X
7) Does the Rhode Island demonstration change access to care for medical, behavioral health, 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 Rhode Island in its demonstration can inform adaptation or replication by other States?	X	X	—	X
9) What strategies used or challenges encountered by Rhode Island in its 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.

2. Rhode Island Demonstration

2.1 Demonstration Goals

The central goal of the Rhode Island Integrated Care Initiative (ICI) Demonstration is to test an innovative payment and service delivery model "to alleviate fragmentation; improve coordination of services for Medicare-Medicaid beneficiaries; enhance quality of care; reduce costs for both the State and the Federal government; meet Enrollees' health and functional needs; improve transitions among care settings; and reduce health disparities" (MOU, 2015, p. 1). Key goals include enhancing person-centered care, improving and maintaining beneficiary quality of life, developing an integrated system of care and coordination of services, increasing the proportion of individuals successfully residing in a community setting, decreasing avoidable hospitalizations and emergency room utilization, reducing nursing facility admissions and length of stay, and promoting alternative payment arrangements (MOU, 2015, pp. 2–3). The demonstration is being implemented as the second phase of a broader ICI in Rhode Island, which is aimed at improving health and well-being and providing better health care at lower costs (MOU, 2015, p. 1). More information on the ICI and its earlier phase is provided in ***Section 2.3***.

2.2 Summary of Demonstration

Under the demonstration, Rhode Island and CMS entered into a three-way contract with an MMP to offer an integrated set of benefits to full-benefit Medicare-Medicaid enrollees aged 21 years or older, including individuals residing in nursing facilities, individuals with intellectual or developmental disabilities, individuals with serious and persistent mental illness (SPMI), individuals residing in the community who receive long-term services and supports (LTSS) and those who do not, and individuals with end-stage renal disease. The following groups of individuals are not eligible to enroll in the demonstration: those who do not meet specified eligibility criteria for full Medicare-Medicaid benefits; individuals who reside at certain facilities serving special populations, including Tavares Pediatric Center and Eleanor Slater Hospital; residents who reside out of State in nursing facilities or hospitals; and individuals who are in hospice at the time of enrollment (MOU, 2015, pp. 7–8). Although the design of the demonstration as set forth in the MOU allows for the participation of more than one MMP, only one MMP is participating in the ICI Demonstration (Three-way contract, 2016). Additional information describing this MMP is in ***Section 2.3***.

Benefits under the demonstration include all medically necessary Medicare (Parts A, B, and D) and Medicaid services, including institutional and home and community-based LTSS, except for certain benefits that will continue to be provided via Medicaid fee for service (FFS): dental services; non-emergency transportation services; home stabilization services; and, for individuals with intellectual or developmental disabilities, residential services. CMS and the State may seek to add those services to the demonstration at a later time (MOU, 2015, pp. 93–94). Behavioral health services will be included as a covered benefit under the ICI demonstration (Three-way Contract, Appendix A). These services include a full continuum of mental health and substance use disorder treatment, including but not limited to: community-based narcotic treatment; methadone, community- or hospital-based detox; mental health/substance use disorder residential treatment; mental health psychiatric rehabilitative residence; psychiatric rehabilitation

day programs; Assertive Community Treatment (ACT); and Integrated Health Home (IHH) and services for individuals at community mental health centers.

The MMP has discretion to offer flexible benefits not traditionally covered by Medicare or Medicaid. In addition, certain supplemental benefits may be considered after the first year of the demonstration, including an integrated pain management program; screening, brief intervention, and referral to treatment; and nonmedical transportation (MOU, 2015, pp. 92–93).

Before this demonstration, Medicare-Medicaid beneficiaries received Medicaid benefits through Rhody Health Options (RHO), a managed care plan providing primary care and LTSS, or through the FFS system. Some beneficiaries had the option of Rhode Island's Program of All-Inclusive Care for the Elderly (PACE) for receipt of all Medicaid and Medicare benefits.

Under the demonstration, all enrollees will receive care management as needed "to support health and wellness, ensure effective linkages and coordination between the primary care provider (PCP) and other providers and services, and to coordinate the full range of medical and behavioral health services, preventive services, medications, LTSS, social supports, and enhanced benefits as needed, both within and outside the MMP" (MOU, 2015, p. 68). Individuals eligible for LTSS or those who are determined to be at high risk as identified through an initial health screen or other sources, will receive intensive care management, which includes assignment to a lead care manager (LCM) and the creation of a comprehensive interdisciplinary care plan (MOU, 2015, p. 71). Individuals who reside in the community and are not eligible for LTSS or otherwise identified as high-risk will first be assessed through a telephonic initial health screen (IHS). People who are stratified into a high-risk category based on the IHS will then have a CFNA. Low- and moderate-risk enrollees per the IHS will be eligible for care coordination services, including routine support from the MMP's enrollee services department, wellness services, and peer navigator services as appropriate to facilitate access to community services (MOU, 2015, pp. 69–70).

Each enrollee will have an interdisciplinary care plan and an interdisciplinary care team (ICT) to coordinate services across the full continuum of care (three-way Contract, p. 12). Each ICT will be based on needs and preferences of the enrollee and, as applicable, include the enrollee's PCP, family members or caregivers, and behavioral health specialist if appropriate; for high-risk individuals, the ICT will be led by the LCM and will include LTSS providers and other key individuals (MOU, 2015, pp. 83–84).

Notices for opt-in enrollment into the demonstration (i.e., when the State will begin to accept enrollment requests) began on June 1, 2016 for coverage starting no sooner than July 1, 2016. Passive enrollment will occur in at least six separate waves; the first effective date is no sooner than October 1, 2016 (personal communication with CMS, December 2015). Individuals who are eligible for the demonstration and who are enrolled in a plan for Medicaid benefits that is operated by the same parent organization as the MMP may be passively enrolled in that same plan (MOU, 2015, p. 8). Individuals enrolled in a Medicare Advantage plan or PACE plan, and who meet the eligibility criteria for this demonstration, may participate in this demonstration if they choose to disenroll from their existing programs. Individuals currently enrolled in PACE will not be passively enrolled (MOU, 2015 pp. 8–9). The State sends notices to individuals who are eligible for the demonstration before the first effective enrollment date. Enrollees who are

subject to passive enrollment receive a 60-day advance notice before the effective date of passive enrollment and a 30-day reminder notice. Passive enrollees may opt out through the last day of the month before the effective date (MOU, 2015, p. 66).

To participate in the demonstration, an MMP has to meet the State's requirements set forth through a competitive procurement process and CMS requirements outlined in multiple sets of capitated Financial Alignment Demonstration guidance, and pass a CMS and State-sponsored readiness review (MOU, 2015, pp. 63–64).[1] This demonstration operates statewide.

Table 2 provides a summary of the key characteristics of the Rhode Island demonstration compared with the current system for demonstration-eligible beneficiaries.

Table 2
Key features of Rhode Island's model predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Summary of covered benefits		
Medicare	Medicare Parts A, B, and D	Medicare Parts A, B, and D
Medicaid	Medicaid State Plan and 1115(a) demonstration items and services, including LTSS	Medicaid State Plan and 1115(a) demonstration items and services, including LTSS, and flexible benefits
Payment method (capitated/FFS/MFFS)		
Medicare	FFS or capitated (Medicare Advantage or PACE)	Capitated
Medicaid (capitated or FFS)		
Primary/medical	FFS except capitated payments for PACE or for RHO enrollees.	Capitated with the exception of FFS for nonemergency medical transportation, dental services, and residential services for ID/DD.
Behavioral health	Capitated for individuals enrolled in RHO, ID/DD services managed through BHDDH continue to be FFS. Capitated for PACE enrollees; FFS for other individuals.	Capitated

(continued)

[1] The readiness review is intended to ensure that an MMP has the capacity to meet all program requirements, including network adequacy and ability to uphold enrollee safeguards and protections. The review includes enrollment systems, staffing capacity, and ability to meet enrollment requirements (MOU, 2015, pp. 6-7). The complete readiness review for Rhode Island is available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RIRRTool.pdf.

Table 2 (continued)
Key features of Rhode Island's model predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
LTSS	Capitated for individuals enrolled in RHO. Capitated for PACE enrollees. FFS and self-direction for other individuals.	Capitated
HCBS waiver services[2]	N/A. See "LTSS" above.	N/A. See "LTSS" above.
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	Individuals in FFS receiving LTSS may be provided care management through the State OCP or through a state-contracted case management agency. Case management may be provided to individuals receiving certain behavioral health and developmental disabilities services funded and managed through BHDDH. Individuals enrolled in a health home receive care coordination from the health home for their qualifying condition(s). For individuals in RHO, the plan provides care coordination of medical, behavioral health, and LTSS. For individuals in PACE, the PACE provider furnishes care coordination of medical, behavioral health, and LTSS.	For high-risk individuals requiring intensive care management, a lead care manager provides care management and coordination for covered and out-of-plan services. For other enrollees, a care coordinator is responsible. Individuals enrolled in a health home will continue to receive care coordination from the health home for their qualifying condition(s) and from the MMP lead care manager for other services.
Care coordination/case management for HCBS waivers and by whom[2]	N/A	N/A
Enrollment/assignment		
Enrollment method	Voluntary enrollment into RHO for Medicaid services, began on November 1, 2013, and continued over a 6-month period. Passive enrollment was used, with an opt-out opportunity. Opt-outs return to (or enroll in) FFS for their Medicaid benefits; FFS Medicare, or Medicare Advantage, or PACE if they qualify.	Beneficiaries may choose to join the participating MMP. Individuals who are enrolled in a plan for Medicaid benefits that is operated by the same parent organization as the MMP may be passively enrolled in the same plan. Before the enrollment effective date and throughout the demonstration, on a monthly basis, beneficiaries may opt out. Enrollees who opt out may return to (or enroll in) RHO or FFS for their Medicaid benefits; FFS Medicare, or Medicare Advantage, or PACE if they qualify.

(continued)

Table 2 (continued)
Key features of Rhode Island's model predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Attribution/assignment method	Eligible individuals were passively enrolled in RHO.	Beneficiaries who are enrolled in a plan for Medicaid benefits that is operated by the same parent organization as the MMP may be passively enrolled into the same plan under the demonstration with an opportunity to opt out.
Implementation		
Geographic area	Statewide, other than PACE	Statewide
Phase-in plan	N/A	Enrollment began with an opt-in period (i.e., when the State will begin accepting enrollment transactions) starting on June 1, 2016, for an effective date no sooner than July 1, 2016. This is being followed by at least six waves of passive enrollment, with the first effective date no sooner than October 1, 2016.
Implementation date	The first effective date for RHO was November 1, 2013.	The MMP began providing coverage for enrollees on July 1, 2016, starting with an opt-in-only enrollment period.

BHDDH = Behavioral Health, Developmental Disabilities, and Hospitals; FFS = fee-for-service; HCBS = home and community-based services; ID/DD = intellectually or developmentally disabled; LTSS = long-term services and supports; MFFS = managed fee-for-service; MMP = Medicare-Medicaid Plan; N/A = not applicable; OCP = Office of Community Programs; PACE = Program of All-Inclusive Care for the Elderly; RHO = Rhody Health Options; SPMI = severe and persistent mental illness.

[1] Information related to the demonstration in this table is from MOU, 2015.

[2] Rhode Island does not offer any Medicaid services through 1915(c) HCBS waivers; rather, all covered services, including HCBS, are provided under the State's 1115(a) demonstration authority (CMS, 2013, p. 2).

Full-benefit Medicare-Medicaid beneficiaries aged 21 or older living in Rhode Island are eligible to participate in the demonstration, with the exception of individuals residing in Tavares Pediatric Center, Eleanor Slater Hospital, or out-of-State hospitals, and those in hospice on the enrollment effective date. According to a fact sheet on the demonstration released with the final MOU, approximately 26,000 individuals will be eligible to participate in the demonstration (EOHHS, 2016). ***Table 3*** describes the characteristics of Medicare-Medicaid beneficiaries enrolled in RHO as of September 1, 2016. The balance of Medicare-Medicaid individuals is currently served by FFS (approximately 8,000 individuals). There were 278 enrollees in the PACE program as of September 1, 2016.

Table 3
Characteristics of the dually eligible population enrolled in RHO as of September 1, 2016

Characteristic	No. of beneficiaries	Percentage of RHO dual-eligible enrollees
Intellectual or developmental disabilities	2,076	10%
Severe and persistent mental illness	1,821	8%
Nursing facility stay > 90 days	2,759	13%
Community residents not receiving LTSS	12,915	60%
Community residents receiving LTSS	1,860	9%
Total	21,431	100%

LTSS = long-term services and supports; RHO = Rhody Health Options.

SOURCE: EOHHS, September 2016.

As shown in ***Table 4***, the total Medicare and Medicaid spending for the eligible population of this demonstration (i.e., those who would have been eligible to participate in the demonstration had it been operational) was $1.66 billion in State fiscal year (SFY) 2013. Of that total, Medicare expenditures accounted for approximately 57 percent and Medicaid 43 percent. The State reports that residential and long-term care expenditures for institutional and home and community-based services constitute more than 94 percent of the Medicaid costs for Medicare-Medicaid beneficiaries, whereas the largest category of spending for Medicare-only individuals is hospital and other acute care costs (Letter of Intent, 2014, p. 14).

Table 4
Total expenditures for Medicare-Medicaid enrollees (full and partial benefits), SFY 2013

Population	Medicaid expenditures	Medicare expenditures	Total expenditures
Eligible population	$714 million	$941.1 million	$1.66 billion

SFY = State fiscal year.

SOURCE: Letter of Intent, 2014, p. 14.

2.3 Relevant Historical and Current Context

History/Experience with (Managed Care/Health Homes). Rhode Island's initial managed care program, RIte Care, began in 1994 to serve low-income children and families. Program eligibility has been expanded several times since implementation, and as of February 2014, RIte Care had a total enrollment of 131,760 members. In December 2005, Rhode Island implemented PACE. In 2007, the State implemented a Medicaid PCCM program called Connect Care Choice (CCC) for adults with complex medical and behavioral health conditions. In 2008, the State launched a fully capitated managed care organization for adults with disabilities and chronic illnesses, called Rhody Health Partners (RHP). Medicare-Medicaid enrollees were not eligible to participate in either CCC or RHP (Letter of Intent, 2014, pp. 10–11).

In January 2009, CMS approved the Rhode Island Comprehensive Section 1115(a) demonstration. The State currently operates its entire Medicaid program under the 1115(a)

demonstration, including services previously provided under home and community-based services (HCBS) 1915(c) waiver authority (CMS, 2013, p. 2). Under the 1115(a) demonstration, enrollment in CCC or RHP became mandatory in fall 2009 for all Medicaid-only adults in the Aged, Blind and Disabled eligibility category with no third-party coverage residing in the community (Letter of Intent, 2014, pp. 10–11). With the exception of PACE, Medicare-Medicaid beneficiaries in Rhode Island remained outside of any Medicaid managed care program. In addition, although CCC and RHP were inclusive of primary care and behavioral health services, LTSS continued to be delivered outside those models on an FFS basis.

In January 2013, Rhode Island sought authority from CMS to undertake the ICI in two phases, which was approved as part of its overall 1115(a) demonstration extension in December 2013. Under Phase I of the ICI, Rhode Island created CCCCP, which added a Coordinating Care Entity (CCE) component to the existing CCC model. For Medicare-Medicaid beneficiaries, the CCE would take responsibility for coordinating care and service integration through working with the CCC practice sites, State Office of Community Partners case managers, and a newly created Community Health Team designed to integrate social supports and services (Letter of Intent, 2013, p. 21). Rhode Island also created RHO, a Medicaid health plan option that included LTSS within the capitation benefit package (Letter of Intent, 2014, p. 18). Certain benefits were not initially included as part of the capitation rate for RHO, including dental services, AIDS nonmedical case management, nonemergency transportation services, residential services for individuals with intellectual and developmental disabilities, and other behavioral health services (Rhode Island Contract with Neighborhood Health Plan of Rhode Island [NHPRI], 2013, Attachment B). Since that time, Rhode Island has moved some of these services in-plan. As of September 2016, dental services, non-emergency transportation, home stabilization services, and residential services for individuals with intellectual and developmental disabilities are included (EOHHS, September 2016). Eligibility for RHO includes Medicare-Medicaid beneficiaries and Medicaid-only individuals receiving LTSS either in the community or in nursing facilities.

Enrollment in CCCCP and RHO began in September 2013 for both Medicaid-only and Medicare-Medicaid beneficiaries. This included several phases of passive enrollment into CCCCP or RHO of both Medicaid-only and Medicare-Medicaid beneficiaries. Enrollment was voluntary on an "opt-out" basis. Individuals choosing to opt out of RHO or CCCCP could remain in FFS to receive their Medicaid benefits, or choose PACE, if eligible. CCCCP and CCC were subsequently terminated in February 2016, as part of Rhode Island's Reinventing Medicaid initiative. As of September 1, 2016, approximately 22,000 Medicaid-only and Medicare-Medicaid beneficiaries were enrolled in RHOEOHHS, September 2016).

The Rhode Island ICI demonstration under the Financial Alignment Initiative is Phase II of the initiative that began in 2013 and is designed to provide coordinated Medicare and Medicaid benefits through an integrated delivery system. As of the date of this evaluation plan, the only prospective MMP for the ICI demonstration is NHPRI. NHPRI is also the only health plan participating in the RHO program, under which it provides Medicaid benefits to Medicaid-only beneficiaries receiving LTSS and Medicare-Medicaid beneficiaries (MOU, 2015, pp. 1–2). In 2014, the State conducted a procurement process for additional RHO plans and MMPs; none were selected (MOU, 2015, pp. 5–6).

Other Initiatives. *Medical Homes:* Rhode Island has a robust approach under way to establish and spread the medical home model in primary care practices across the State. The Rhode Island Chronic Care Sustainability Initiative (CSI-RI) was one of the first multipayer, patient-centered medical home initiatives in the country (CSI-RI and Rhode Island Quality Institute, 2014). The CSI-RI corresponded with a State directive for health plans to invest an additional $100 million in primary care, beginning with payment to five participating practices in October 2008. This initiative is now known as the Care Transformation Collaborative of Rhode Island. Payers included commercial and Medicaid managed care participants; Medicare joined as a payer on behalf of Medicare FFS beneficiaries in 2011 through the selection of Rhode Island to participate in the Medicare Advanced Primary Care Practice demonstration (RTI International, The Urban Institute, and the National Academy for State Health Policy, January 2015). Since its beginning, the CTC-RI has expanded to include a total of 73 adult primary care sites, with 20 new sites being added each year (EOHHS, September 2016).

Health Homes: Rhode Island has three health home State Plan Amendments approved by CMS. Individuals who enroll in Rhode Island's ICI demonstration under the Financial Alignment Initiative may also be enrolled in a health home, and the MMP will be required to coordinate with the health home for both health home and MMP services (MOU, 2015, pp. 71–72).

Money Follows the Person (MFP) and Other Rebalancing Efforts: In SFY 2011, Medicaid spending on long-term care services was $423.5 million. In SFY 2011, institutional care expenditures made up 86 percent of all long-term care services expenditures, compared with 14 percent for HCBS. Rhode Island has a significantly higher rate of nursing facility utilization than the national average, with 56 nursing facility residents per 1,000 individuals, compared with 38 per 1,000 nationally. In addition, Rhode Island nursing facility residents are less impaired and have a lower severity of need than the national average (Letter of Intent, 2013, p. 16).

In response to this issue, over the past decade Rhode Island has worked on several approaches to rebalance its institutional versus community-based care. Strategies included State legislation, use of the Real Choice Systems Transformation Grant to improve information and referral and LTSS, creation of a Long Term Care Coordinating Council, and a Nursing Home Transition program. In April 2011, Rhode Island also received an MFP demonstration grant from CMS, enabling the creation of the Rhode to Home (RTH) program. RTH uses transition coordinators to provide intensive case management to older adults and individuals with disabilities in the early stages of their transition from an institution to a community setting, including ensuring that appropriate community-based services are put in place. Peer-mentoring services are also made available to further support those in transition (Letter of Intent, 2013, p. 18). The ICI demonstration will be coordinated with Rhode Island's MFP program (MOU, 2015, p. 27). For enrollees in the demonstration residing in nursing facilities who wish to move to the community, the MMP must comply with RTH guidelines for transition, ensure that all community supports are in place before transition, and provide necessary interface and coordination with and among clinical services and community LTSS (MOU, 2015, p. 96).

3. Demonstration Implementation Evaluation

3.1 Purpose

The evaluation of the implementation process is designed to answer the following overarching questions about the Rhode Island demonstration:

- What are the primary design features of the Rhode Island demonstration, and how do they differ from the State's previous system available to the demonstration-eligible population?
- To what extent did Rhode Island 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 Rhode Island 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 Rhode Island 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 Rhode Island 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

The RTI evaluation team's analysis of the implementation of the Rhode Island demonstration will be organized by these key demonstration design features. This framework will be used to define the team's areas of inquiry, structure the demonstration variables we track, organize information from the team's data collection sources, and outline an annual report. ***Table 5*** illustrates the key components of each design feature that we will monitor as part of the implementation evaluation. RTI's 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)	▪ MMPs ▪ 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
Integrated delivery systems supports	▪ Care team composition ▪ Health IT applied throughout the demonstration (at State level, by MMPs, at provider level, or other) ▪ Data (Medicare claims or encounter data) and other feedback to MMPs, medical/health homes, 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 ▪ Opt-out, disenrollment, and auto-assignment policy ▪ Assignment/referrals to providers, health homes, medical homes ▪ Phased enrollment of eligible populations ▪ Workforce development for worker supply and new functions

(continued)

Table 5 (continued)
Demonstration design features and key components

Design feature	Key components
Beneficiary engagement and protections	▪ State 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
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 MMPs and/or to providers
Elements of payments to MMPs and providers	▪ Incentives ▪ Shared savings ▪ Risk adjustment

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

3.4 Implementation Tracking Elements

Through document review and interviews with State agency staff, the RTI team will identify and describe the delivery system for Medicare-Medicaid enrollees in the eligible population. This will enable us to identify key elements that Rhode Island 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, the team will conduct a descriptive analysis of Rhode Island key demonstration features.

The evaluation will analyze how Rhode Island is carrying out its implementation plan and track any changes it makes to its initial design as implementation proceeds. The RTI team will identify both planned changes that are part of the demonstration design (e.g., phasing in new populations) and operational and policy modifications Rhode Island makes based on changing circumstances. Finally, the team anticipates 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 ongoing communication with the State, the RTI team will collect detailed information on how Rhode Island 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. RTI will also identify ways that the scope of care coordination activities conducted under the demonstration by managed care organizations compares with the State's approach in its capitated model programs serving other populations.

The RTI evaluation team 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 Rhode Island's entries. The team will make additional calls to State agency staff, CMS, and key informants as needed to keep abreast of demonstration developments. RTI will use site visit interviews to learn more about what factors are facilitating or impeding progress or leading to revisions in the Rhode Island demonstration implementation.

Table 6 shows the types of demonstration implementation elements the RTI evaluation team 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	▪ Contracts with Medicare-Medicaid Plans (MMPs) Documentation of coordination activities between MMPs and community-based organizations ▪ New waiver authorities submitted for the demonstration and approved by CMS ▪ Emergence of new medical homes and health homes ▪ 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
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* MMP-level reporting on quality improvement) ▪ State efforts to build MMP and provider core competencies for serving beneficiaries with various types of disabilities ▪ Provision of regular feedback to MMPs and providers on the results of their performance measures

(continued)

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

Design feature	Tracking elements
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, LTSS, and behavioral health services ▪ State approaches to stratify care coordination intensity based on individual needs ▪ 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
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 MMP/providers ▪ Options counseling and information provided by Aging and Disability Resource Centers and State Health Insurance Assistance Programs ▪ 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 State 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.

3.5 Progress Indicators

In addition to tracking implementation of demonstration design features, the RTI evaluation team will also track progress indicators, including growth in enrollment and disenrollment patterns, based on Rhode Island demonstration data. These progress indicators will be reported quarterly by Rhode Island 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 Rhode Island demonstration design and progress, to capture data elements on a quarterly basis, and to monitor and report on demonstration progress by individual States and the demonstration 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
No. of beneficiaries automatically (passively) enrolled in the demonstration
Disenrollment
No. of beneficiaries who opted out of the demonstration before 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
Whether demonstration is currently statewide versus in specific counties or geographic areas (and provide list if in specific geographic areas)
Specific to capitated model demonstrations
No. of three-way contracts with MMPs
Specific to demonstrations that use health homes
No. of health homes participating in the demonstration
No. of enrollees receiving health home services currently participating in the demonstration
Specific to demonstrations utilizing certified medical homes
No. of medical homes serving demonstration enrollees
No. of demonstration enrollees served by medical homes

MMP = Medicare-Medicaid Plan.

3.6 Data Sources

The evaluation team will use a variety of data sources to assess whether the Rhode Island 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-specific documents that specify the Rhode Island approach to implementing the demonstration in order to develop a baseline profile of the current delivery system. Review of the Rhode Island agreement with CMS articulated through the demonstration Memorandum of Understanding (MOU), waivers, contracts, State Plan Amendments, and MOUs between health homes and providers will further enhance RTI's understanding of the Rhode Island approach.

- **Demonstration data (collected via the SDRS):** On a quarterly basis, the RTI team will collect data from Rhode Island to inform ongoing analysis and feedback to the State and CMS throughout the demonstration. Specifically, RTI 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 SDRS.

- **State agency staff, stakeholders, selected contractors, and Medicare-Medicaid Plan (MMP):** There will be at least two site visits; the first one will occur within 6 months of demonstration implementation. Using two-person teams, supplemented with telephone interviews, the RTI team will obtain perspectives from key informants on progress to date, internal and external environmental changes, reasons Rhode Island 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, RTI 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:

  - Federal and State Representatives from the CMS–State Contract Management Team
  - Representatives from the MMP
  - State officials, such as:
    - Secretary of State health and human services agency
    - State Medicaid director

- Chief medical officer
- Chief quality officer
- Demonstration project director
- Long-term services and supports program director
- State Medicaid agency finance manager
- Representatives from the demonstration advisory committee
- State behavioral health director
- State developmental disabilities director

– Representatives from health home providers

– Representatives from other providers and provider associations

– Area Agency on Aging

– Representatives from entities providing options counseling for the demonstration

– Representatives from the demonstration ombuds program

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 Rhode Island demonstration. Questions will be tailored to the key informants in Rhode Island, 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 before the site visit. The site visit interview protocols with core questions are provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013), and will be tailored for Rhode Island after the demonstration begins. Before the site visits, the RTI team will contact the State to help identify the appropriate individuals to interview. RTI will work with the State to schedule the site visit and the on-site interviews. The RTI team will develop an interview schedule that best suits the needs of the State and key informants the team plans to interview.

3.7 Analytic Methods

Evaluation of the Rhode Island 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. The RTI evaluation team will collect and report quantitative data quarterly as noted in ***Table 7***, ***Examples of Progress Indicators***, through the SDRS. RTI will integrate these

quantitative data with qualitative data the team 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 Rhode Island has made to the preexisting delivery systems serving Medicare-Medicaid enrollees, (2) challenges Rhode Island has met, and (3) approaches that can inform adaptation or replication by other States.

4. Impact and Outcomes

4.1 Beneficiary Experience

4.1.1 Overview and Purpose

The evaluation will assess the impact of the Rhode Island demonstration on beneficiary experience. Using mixed methods (i.e., qualitative and quantitative approaches), the RTI evaluation team will monitor and evaluate the experience of beneficiaries, their families, and caregivers. The team's 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 Rhode Island, CMS, or other entities (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]);
- Rhode Island 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 obtained from CMS to analyze utilization as well as access to services and outcomes for key quality measures; and
- interviews with Rhode Island 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 the RTI team will use to monitor and evaluate beneficiary experience. The team is 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, the team 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 RTI will use to monitor and evaluate beneficiary experience such as focus groups with beneficiaries and interviews with consumer and advocacy groups. RTI also discusses information about data that the evaluation team will obtain from Rhode Island 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), the RTI evaluation team also will explore whether we can identify specific demonstration features in Rhode Island that may influence replication in other States. RTI 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 SDRS. ***Section 3, Demonstration Implementation Evaluation***, describes topics RTI will monitor and document through interviews with Rhode Island 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 RTI will use these data to inform RTI's understanding of the impact of the demonstration on access to care and health outcomes.

Specifically, the RTI evaluation team will address the following research questions in this section:

- What impact does the Rhode Island 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 Rhode Island, 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, RTI 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.

RTI's 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
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	Rhode Island demonstration data[2]	Interviews with Rhode Island agency staff on demonstration implementation
Integrated delivery system					
Choice					
Beneficiaries have choice of medical, behavioral, and LTSS *services*.	X	X	X	X	X
Beneficiaries have choice of medical, 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 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]	Rhode Island demonstration data[2]	Interviews with Rhode Island 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 into the 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, 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]	Rhode Island demonstration data[2]	Interviews with Rhode Island 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]	Rhode Island demonstration data[2]	Interviews with Rhode Island agency staff on demonstration implementation
Care coordination					
Assessment of need Assessment process integrates/addresses health, 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]	Rhode Island demonstration data[2]	Interviews with Rhode Island 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]	Rhode Island demonstration data[2]	Interviews with Rhode Island 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, grievances, 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 auto-assignment (if available).	—	—	—	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 results, or from other beneficiary surveys that may be conducted by the State or other entities.

Table 8 aligns key elements identified in the CHCS framework with the demonstration design features described in ***Section 3, Demonstration Implementation Evaluation***. RTI 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, RTI identifies the impact on beneficiary experience and details the data sources that the team will use to obtain the information.

As shown in ***Table 8***, the RTI evaluation team 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). RTI will include topics specific to the demonstration and supplement the team's 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 Rhode Island staff on demonstration implementation.

Table 9 highlights some of the quantitative measures of beneficiary experience RTI 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 the RTI evaluation team plans to examine as part of the overall evaluation of impact of the Rhode Island 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).

The RTI evaluation team will analyze the findings by special population. When the team can recruit sufficient numbers of individuals from the special populations of interest to participate in the focus groups, RTI will also analyze the evaluation team's focus group findings about beneficiary experience to determine whether differences exist by special population, such as racial and ethnic minorities.

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

Rate of auto-assignment to Medicare-Medicaid Plans (MMPs) (if available)
Rate of disenrollment from the demonstration by reason[1]
Rate of beneficiaries who opt out of enrolling into the demonstration
Number and type of beneficiary complaints, grievances, and appeals
Use of preventive services[1]
Nursing facility admissions and readmissions[1]
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

The RTI evaluation team will rely on five major data sources to assess beneficiary experience as shown in ***Table 8***. This section describes RTI's 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

The RTI evaluation team will conduct at least four focus groups in Rhode Island to gain insight into how the initiative affects beneficiaries. To ensure that the team captures the direct experience and observations of those served by the Rhode Island demonstration, focus groups will be limited to demonstration enrollees, their family members, and informal caregivers. ***Table 10*** shows the current plan for the composition and number of 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 RTI's assessment of whether there is more to be learned about the experience of beneficiaries shortly after initial enrollment into the Rhode Island demonstration versus their perceptions of its effectiveness later in the Rhode Island demonstration. If the latter, RTI will conduct focus groups at least 9 months after implementation so that beneficiaries have had a substantial amount of experience with the demonstration. RTI 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. Beneficiaries may include those receiving LTSS in the community or in a nursing facility. The focus groups may include but are not limited to beneficiaries with the following: ▪ developmental disabilities ▪ severe and persistent mental illness ▪ substance use disorders ▪ multiple chronic conditions
Number	At least four focus groups

LTSS = long-term services and supports.

The RTI evaluation team will recruit focus group participants from eligibility and enrollment files independent of input from the State. In doing so, the team will identify beneficiaries reflecting a range of eligibility, clinical, and demographic characteristics enrolled in the Rhode Island demonstration. RTI's 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 Rhode Island, the RTI team will consider convening focus groups with beneficiaries who have chosen to opt out or disenroll to understand their decisions. RTI will work closely with Rhode Island demonstration 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 Rhode Island. RTI 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 RTI's understanding of issues raised during implementation of the Rhode Island demonstration.

4.1.3.2 Key Stakeholder Interviews

The RTI evaluation team will conduct key stakeholder interviews (consumer and advocacy groups) in Rhode Island, either in person as part of a scheduled site visit or by telephone, with major beneficiary groups whose stakeholders are served by the Rhode Island 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 RTI will interview service providers as part of the evaluation team's implementation analyses, service provider perspectives will not be the source of information for assessing beneficiary experience.

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

A draft outline of the key stakeholder interview at baseline is presented in the *Aggregate Evaluation Plan* (Walsh et al., 2013). RTI will revise this draft as the evaluation team obtains more information about the Rhode Island demonstration and the issues that arise during its planning/design phase and early implementation.

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 Rhode Island demonstration. These may include the following: ▪ Advocacy and consumer organizations representing the demonstration's eligible populations ▪ Advocacy and consumer organizations participating in Rhode Island's Medicaid Advisory Committee and its subcommittees ▪ Beneficiaries serving on Consumer Advisory Committees ▪ 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 Rhode Island 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.

4.1.3.3 Beneficiary Surveys

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

As part of CMS requirements for capitated model plans, Medicare-Medicaid Plans (MMPs) will be required to conduct the Health Outcomes Survey (HOS) and CAHPS. The Medicare CAHPS survey and HOS 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, such as quality of life measures. Topics on which RTI will recommend common questions across State demonstrations are shown in ***Table 8***.

4.1.3.4 Demonstration Data

RTI will use data about the demonstration that the evaluation team collects from Rhode Island 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, Rhode Island plans to monitor quality using State-specific measures focused on nursing facility diversion and rebalancing as well as other measures related to falls, use of antipsychotic medications for dementia, and care planning (Memorandum of Understanding [MOU], 2015, pp. 124–27). To the extent relevant, RTI will use findings from these State-specific metrics to augment RTI's assessment of beneficiary experience and outcomes in Rhode Island.

4.1.3.5 Interviews with Rhode Island Demonstration Staff

In addition to key stakeholder interviews conducted with consumer and advocacy groups, RTI will address issues of beneficiary engagement and feedback during RTI's interviews with Rhode Island demonstration staff. These interviews, described in ***Section 3***, will provide another perspective on how Rhode Island communicates and works with beneficiaries during the design and implementation of its demonstration.

4.1.4 Analytic Methods

The RTI evaluation team's analysis will assess beneficiary experience and determine, where possible, how it is affected by financial model and demonstration design features. RTI also wants 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 Rhode Island and compare and contrast those themes by special population within and across States. Because it is implementing a capitated financial alignment model demonstration, the evaluation team is particularly interested in comparing Rhode Island's findings with those of capitated financial alignment 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 SDRS. The RTI evaluation team will also request summary statistics and reports from Rhode Island, CMS, or other entities based on any evaluation activities related to this demonstration. 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 predemonstration 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 RTI will focus in evaluating the Rhode Island 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 Rhode Island demonstration have on utilization patterns in acute, long-term, and behavioral health services, overall and for beneficiary subgroups?

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

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

- What impact does the Rhode Island demonstration have on cost, and is there evidence of cost savings in the State? How long did it take to observe cost savings in the State? How were these savings achieved in the State?

This section discusses the RTI evaluation team's approach to identifying the eligible population for Rhode Island 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 Rhode Island demonstration. Results of descriptive analyses focusing on differences across years and important subgroups on key outcome variables will be included in the Rhode Island 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 Rhode Island demonstration whereby the beneficiaries choosing not to enroll in the demonstration may differ from demonstration

participants. First, beneficiaries may choose to opt out or disenroll from the demonstration. Reasons for opting out or disenrolling will vary but may be related to demonstration benefits or previous experience in managed care. Second, although Rhode Island intends to implement the demonstration statewide, beneficiaries may not be able to enroll if there is limited managed care penetration in some regions of the State. Third, beneficiaries already enrolled in a Medicare Advantage plan that is not also an MMP and beneficiaries enrolled in a Program of All- Inclusive Care for the Elderly will not be eligible for passive enrollment into the demonstration but can choose to disenroll from their current plans or programs in order to enroll in the demonstration. To limit selection bias in the evaluation of this demonstration, RTI will use an intent-to-treat design. This design will address potential selection issues by including the entire population of beneficiaries eligible for the Rhode Island Integrated Care Initiative demonstration, regardless of whether they enroll in the demonstration or actively engage in Rhody Health Options (RHO) MMPs.

Under the intent-to-treat framework, outcome analyses will include all beneficiaries eligible for the demonstration in the demonstration States, including those who opt out, 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 demonstrations on all beneficiaries in the demonstration-eligible population. In addition, RTI will compare the characteristics of beneficiaries who enroll in the MMP 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 Rhode Island will include full-benefit Medicare-Medicaid enrollees who are aged 21 years or older at the time of eligibility determination. Individuals who reside at certain facilities, including Tavares Pediatric Center, Eleanor Slater Hospital, or out-of-State facilities, and individuals who are in hospice at the time of enrollment, are not eligible for participation. To analyze quality, utilization, and costs in the predemonstration period, and throughout the demonstration period, Rhode Island 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 Rhode Island intends to implement the demonstration statewide, the RTI evaluation team will consider a comparison group from out-of-State Metropolitan Statistical Areas. In general, RTI expects to draw such groups from multiple comparison States and areas. However, if for some reason the Rhode Island demonstration is not implemented statewide, RTI will determine whether there are areas within Rhode Island that could also be part of the comparison group. The approach for identifying an in-State potential comparison area would be the same as that for an out-of-State comparison group, described below.

The RTI evaluation team will use statistical distance analysis to identify potential comparison areas that are most similar to Rhode Island in regard to costs, care delivery arrangements, policy affecting Medicare-Medicaid enrollees, population density, and the supply of medical resources. The specific measures for the statistical distance analysis RTI will use are Medicare spending per Medicare-Medicaid enrollee, Medicaid spending per Medicare-Medicaid

enrollee, nursing facility users per 65-and-over Medicaid beneficiary, home and community-based services (HCBS) users per 65-and-over Medicaid beneficiary, Personal Care users per 65-and-over Medicaid beneficiary, Medicare Advantage, 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 a comparison State or States is/are selected, all Medicare-Medicaid enrollees in those States 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, the RTI evaluation team will compute propensity scores and weight comparison group beneficiaries using the framework described in ***Section 4.2.2.4*** of this report.

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 between the comparison group member and the demonstration group members.

2. **Sample size:** Given that the team plans to use all comparable beneficiaries in an out-of-State comparison group that would be eligible for the demonstration, RTI expects to have sufficient sample size for the statewide analyses and for analyses of smaller special populations.

3. **Accounting for enrollment in other demonstrations:** Some Medicare-Medicaid enrollees may not be suitable for comparison group selection because of participation in other shared savings programs including enrollment in Medicare Accountable Care Organizations. RTI will work with CMS to specify these parameters and apply them to both Rhode Island 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) data submissions will need to be considered if, as expected, 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, the RTI evaluation team 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, the evaluation team 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, the team 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 Rhode Island evaluation of quality, utilization, and cost. Data sources include Medicare and Medicaid fee-for-service (FFS) data, Medicare Advantage encounter data, and MMP 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 FFS or Medicare Advantage in the pre- and postdemonstration periods.

The terms of the Rhode Island MOU require the State to provide timely Medicaid data through MSIS for the predemonstration and demonstration periods. Any delays in obtaining data may also delay portions of the evaluation.

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.

Table 13
Data sources to be used in the Rhode Island 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 the demonstration, have disenrolled, or do not enroll for other reasons; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years before 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 the demonstration, have disenrolled, or do not enroll for other reasons; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years before the demonstration; and for comparison groups.	Pre- and postperiod beneficiary encounter data (including Medicare Advantage, and MMP, and 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 the demonstration, have disenrolled, or do not enroll for other reasons; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years before the demonstration; and for comparison groups that may be in State and/or out of State.
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 (file on inpatient care, institutional, and the "other" file) ▪ Medicaid eligibility files	Data will be collected from the following: ▪ CMS ▪ Medicare enrollment data

(continued)

Table 13 (continued)
Data sources to be used in the Rhode Island demonstration evaluation analyses of quality, utilization, and cost

Aspect	Medicare fee-for-service data	Medicaid fee-for-service data	Encounter data[1]
Time frame of data	Baseline file = 2 years before the demonstration period (NCH Standard Analytic File). Evaluation file = all demonstration years (NCH TAP Files).	Baseline file = 2 years before 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 MMP 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; MMP = Medicare-Medicaid Plan; MSIS = Medicaid Statistical Information System; NCH = National Claims History; TAP = monthly Medicare claims files.

[1] Encounter data from Medicare Advantage (MA) or Program of All-Inclusive Care for the Elderly (PACE) plans in the pre-period are needed to evaluate demonstration effects for beneficiaries who previously were enrolled in MA or PACE plans but who enroll in the demonstration. There may also be movement between MA or PACE plans and the demonstration throughout implementation, which the RTI evaluation team will need to take into account using MA or PACE encounter data during the implementation period.

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.umn.edu/medicare/requesting_data.asp.

4.3 Analyses

The analyses of quantitative data on quality, utilization, and cost measures in the Rhode Island 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 Rhode Island 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 an out-of-State 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 Rhode Island will be based on the demonstration implementation date and, therefore, may represent a "performance period," not necessarily 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 FFS, MMP encounter data, MSIS files, or other data provided by Rhode Island 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 (PMPM), and all-cause hospital readmission and mortality. The RTI evaluation team 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.

Table 14
Quantitative analyses to be performed for Rhode Island 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 before 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 of Quality, Utilization, and Cost Measures

The RTI evaluation team will conduct a descriptive analysis of quality, utilization, and cost measures for the Rhode Island 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, RTI 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 FFS data and MMP encounter data may be available sooner than Medicaid FFS data. Therefore, the RTI evaluation team expects that the first annual report will include predemonstration Medicare and Medicaid FFS data and Medicare FFS, Medicare Advantage, and MMP encounter data for the demonstration period. Medicaid FFS 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 chose not to participate, opt out of the demonstration or disenroll, or actively engage in the MMP. 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.

Because the State is planning to phase in enrollment, first for those who actively select an MMP and later with four waves of passive enrollment, those who are passively enrolled later in the year will be identified by setting a dummy variable flag so that the analysis can determine whether the experience of those who passively enroll differs from that of those who actively enroll. The MOU indicates that the first wave of passive enrollment may include those who are eligible for LTSS in the community, the second may include those residing in nursing facilities, the third may include those who are not eligible for LTSS, and the fourth may include those who are severely and persistently mentally ill. 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.

The RTI evaluation team will measure predemonstration and annual utilization rates for each service type and PMPM costs 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. RTI will calculate average use rates and PMPM costs 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. RTI 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 those receiving LTSS in the community and institutional settings, those receiving behavioral health services, elderly beneficiaries with and without disabilities, and nonelderly beneficiaries with disabilities.

4.3.3 Multivariate Analyses of Quality, Utilization, and Cost Measures

In the final year of the evaluation, the RTI evaluation team will use data collected for the eligible population in Rhode Island 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 special populations of focus in the Rhode Island demonstration, RTI will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and behavioral health services; the RTI team will also examine qualitative data gathered through interviews, focus groups, and surveys. These populations would include those with intellectual or developmental disabilities (ID/DD), severe or persistent mental illness, and with LTSS needs.

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 and not using behavioral health services, LTSS). 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 MMP 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, MMP and Medicaid MCOs [RHO])	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; MMP = Medicare-Medicaid Plan; PAS = personal assistance services; RHO = Rhody Health Options.

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

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

The RTI evaluation team anticipates 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 MMPs are required to submit have not been finalized. RTI will continue to work closely with CMS to understand how these data can best be used by the evaluation.

Under the demonstration, individuals receive their Medicaid benefits through an integrated MMP. In addition, there are a number of services that are carved out of MMPs, including dental services, HIV medical and nonmedical case management, nonemergency transportation services, residential services, day employment supports, and family supports for enrollees with ID/DD. As a result, claims and encounter data will be required from each of these sources.

Currently, CMS has not uploaded any Rhode Island MSIS data in the alphaMAX system for claims processed after the third quarter of 2012. Moreover, a new encounter data system was planned for spring 2013 that was designed to provide records essentially similar to those of FFS claims in terms of structure, quality, and detail. It is not clear how much, if any, historical data will be available once the new system is operational, including for Medicare-Medicaid beneficiaries who may be enrolled in RHO, the State's Medicaid managed care organization, in the early part of 2013, 2 years before the start of the demonstration. Without complete encounter data for 2013, the evaluation team will be unable to analyze service use, cost, and outcomes during the predemonstration period for those enrolled in the RHO. Also, any delay in converting its encounter data system will jeopardize the evaluation team's ability to analyze Medicaid service use, cost, and outcomes for enrolled individuals during the demonstration period.

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 Rhode Island, 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 Rhode Island requires its MMPs to report, and any beneficiary survey data collected by Rhode Island, CMS, or other entities (e.g., CAHPS). CMS and Rhode Island have also identified a set of quality measures that will determine the amount of quality withhold payments (i.e., RIte Care plans must meet quality standards to earn back a withheld portion of their capitated payments). The quality withhold measures, listed in the Rhode Island MOU, 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 Rhode Island. ***Table 16*** provides a working list of the core quality measures to be included in the evaluation of the Rhode Island 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 Rhode Island demonstration. RTI will finalize State-specific quality measures within the first year of implementation and will obtain the needed data from CMS or other sources; Rhode Island 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, RTI 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 people with developmental disabilities or behavioral health conditions). RTI will continue to work with CMS and the State to identify measures relevant to Rhode Island 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 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.
Pressure ulcers Percent of high-risk residents with pressure ulcers (long stay)	MDS RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of all demonstration-eligible long-stay residents in a nursing facility with an annual, quarterly, significant change, or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2–4 pressure ulcer(s).	Numerators: Number of demonstration-eligible Medicare-Medicaid enrollees who are long-stay nursing facility residents who have been assessed with annual, quarterly, significant change, or significant correction MDS 3.0 assessments during the selected time window and who are defined as high risk with one or more Stage 2–4 pressure ulcer(s). Denominators: Number of demonstration-eligible Medicare-Medicaid enrollees who are long-stay residents who received an annual, quarterly, or significant change or significant correction assessment during the target quarter and who did not meet exclusion criteria.

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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.

(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
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 condition; AHRQ = Agency for Healthcare Research and Quality; AMI = acute myocardial infarction; ARB = angiotensin II receptor blocker; BMI = body mass index; BP = blood pressure; CABG = coronary artery bypass grafting; CHF =congestive heart failure; COPD = chronic obstructive pulmonary disease; CR = cardiac rehabilitation; 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); MDS = Minimum Data Set; 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 January 8, 2016.

4.6 Cost

To determine annual total costs (overall and by payer), the RTI evaluation team will aggregate the Medicare and Medicaid PMPM payments to the MMPs, FFS Medicaid payments for dental, HIV, and ID/DD residential services for MMP enrollees, 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. Any retrospective performance payments to the State will also be included in the final impact analysis.

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. RTI will present results for important subgroups, and in more detail to better understand their demonstration experience. RTI will also create a high-cost-user category and track costs of this group over time. To do this, RTI 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 RTI 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.

The RTI team 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. 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. RTI will estimate cost savings accruing to the Medicare and Medicaid programs separately.

4.7 Analytic Challenges

Obtaining Medicaid FFS data for the predemonstration and demonstration periods, RHO encounter data for the predemonstration and postdemonstration periods, and MMP encounter data for the demonstration period will be critical for the evaluation. The Medicaid MMP encounter data are necessary to measure quality, utilization, and costs. It will be important for Rhode Island to submit Medicaid FFS and RHO 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. Because the timing and availability of MMP encounter data are being finalized, 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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