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

California Evaluation Design Plan

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Executive Summary

The California demonstration under the Financial Alignment Initiative will contract with Medicare-Medicaid Plans (MMPs, known in California as MediConnect Plans) to provide services to full-benefit Medicare-Medicaid enrollees aged 21 and older in 8 of the State's 58 counties. The following populations are not eligible for enrollment: individuals receiving services through California's regional centers or State developmental centers or intermediate care facilities for the developmentally disabled; individuals residing in one of the Veterans' Homes of California; or individuals residing in certain rural zip codes in San Bernardino, Los Angeles, and Riverside counties. Other groups not included in the demonstration are individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment who reside in Alameda, Los Angeles, Riverside, San Bernardino, San Diego, and Santa Clara counties; beneficiaries with a share of cost who do not meet share-of-cost requirements; and individuals who have other private or public health insurance. The MediConnect Plans will be responsible for delivery and coordination of all medical, behavioral health, and long-term services and supports (LTSS) for their enrollees. Specialty mental health and substance use services financed and administered by the counties will continue to be delivered outside of the demonstration; however, the MediConnect Plans are responsible for coordinating with county agencies for those beneficiaries.

Enrollees in four counties (Alameda, Riverside, San Bernardino, and Santa Clara) will have a choice of two plans. Enrollees in San Diego and Los Angeles counties will have a choice of four or more plans. Enrollees in the two County Organized Health System (COHS) counties of Orange and San Mateo will be enrolled in the COHS plan, the countywide public health plan that serves all Medi-Cal beneficiaries (Medi-Cal is California's Medicaid program). Plans will be paid a blended, capitated rate covering all Medicare and Medi-Cal services under three-way contracts between the plans, the State, and the Centers for Medicare & Medicaid Services (CMS). The demonstration, known as Cal MediConnect, began on April 1, 2014 (CMS and State of California [hereafter Memorandum of Understanding, MOU], 2013; State of California, Department of Health Care Services, 2013).

CMS contracted with RTI International to monitor the implementation of 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 California demonstration as of July 9, 2014. The evaluation activities may be revised if modifications are made to either the California demonstration or to the activities described in the *Aggregate Evaluation Plan* (Walsh et al., 2013). Although this document will not be revised to address all changes that may occur, the annual and final evaluation reports will note areas where the evaluation as executed differs from this evaluation plan.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on the beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for subpopulations (e.g., people with mental illness and/or substance

use disorders, LTSS recipients). To achieve these goals, RTI will collect qualitative and quantitative data from California each quarter; analyze Medicare and Medi-Cal 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 established a contract management team and engaged an operations support contractor to monitor fulfillment of the demonstration requirements outlined in the MOU and three-way contracts, including MediConnect Plan-level monitoring. RTI will integrate that information into the evaluation as appropriate.

Demonstration Implementation Evaluation of demonstration implementation will be based on case study methods and quantitative data analysis of enrollment patterns. We will monitor progress and revisions to the demonstration, and will identify transferable lessons from the California 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 5*** in ***Section 3*** of this report provides a list of the implementation tracking elements that RTI will monitor for each design feature. Examples of tracking elements include efforts to build plan and provider core competencies for serving beneficiaries with various disability types; requirements for coordination and integration of clinical, LTSS, and behavioral health services; documentation of coordination activities among MediConnect Plans, county Mental Health Plans, Drug Medi-Cal agencies, 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 we gather about implementation will be used for within-State and aggregate analyses; included in the 6-month implementation report to CMS and the State, and annual reports; and will provide context for all aspects of the evaluation.

Beneficiary Experience. The impact of this demonstration on beneficiary experience is a critical focus of the evaluation. Our framework for evaluating beneficiary experience is influenced by work conducted by the Center for Health Care Strategies (CHCS) on the elements of integration that directly affect beneficiary experience for Medicare-Medicaid enrollees. ***Table 7*** in ***Section 4*** of this report aligns key elements identified in the CHCS framework with the demonstration design features listed in the demonstration implementation section. The goals of these analyses are to examine the beneficiary experience and how it varies by subpopulation,

and whether the demonstration has had the desired impact on beneficiary outcomes, including quality of life.

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

To understand beneficiary experience, we 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. We will also obtain data on grievances and appeals from CMS and, as available, other sources. Focus groups will include Medicare-Medicaid enrollees from a variety of

subpopulations, such as 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 California 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 MediConnect Plan, and a group of similar individuals in the comparison group. This approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration-eligible population. RTI will compare the characteristics of those who enroll with those who are eligible but do not enroll, 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, California 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 California does not intend to implement its demonstration statewide, RTI will consider an in-State comparison group. If, however, the areas that will not be included in the demonstration are not sufficiently similar to the demonstration areas, or there are not enough Medicare-Medicaid enrollees in those areas, we will consider using beneficiaries from both within California and from out of California Metropolitan Statistical Areas (MSAs) similar to the demonstration areas. We will use statistical distance analysis to identify potential in-State and out-of-State comparison MSAs that are most similar to the demonstration areas in regard to environmental variables, including costs, care delivery arrangements, and policy affecting Medicare-Medicaid enrollees.

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

the comparison group any beneficiaries with a propensity score lower than the lowest score found in the demonstration group.

The comparison areas will be determined within the first year of implementation in order to use the timeliest data available. The comparison group members will be determined retrospectively at the end of each demonstration year, allowing us to include information on individuals newly eligible or ineligible for the demonstration during that year and to include counties with later start dates.

Analyses. Analyses of quality, utilization, and cost in the California 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 California demonstration.

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

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

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

Subpopulation Analyses. For subpopulations of focus in the California demonstration, we will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and behavioral health services, and also examine qualitative data gathered through interviews, focus groups, and surveys. Descriptive analyses for annual reports will present results on selected measures stratified by subpopulations (e.g., those using and not using behavioral health services, LTSS). Multivariate analyses performed for the final evaluation will account for differential effects for subpopulations to understand whether quality, utilization, and cost are higher or lower for these groups.

Utilization and Access to Care. Medicare, Medi-Cal, and MediConnect Plan encounter data will be used to evaluate changes in the levels and types of services used, ranging along a continuum from institutional care to care provided at home and including changes in the percentage of enrollees receiving supports in the community or residing in institutional settings (see ***Table 14*** 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 15*** of this report). We will supplement these core measures with the following:

- Additional quality measures specific to California that RTI will identify for the evaluation, which will also be available through claims and encounter data that RTI will obtain from CMS. 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 ***Section 4.1*** and ***Section 4.2***.

- HEDIS measures that MediConnect Plans are required to submit, as outlined in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements (CMS, 2014).

- Beneficiary surveys, such as Health Outcomes Survey (HOS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS), that MediConnect Plans are required to report to CMS.

Cost. To determine annual total costs (overall and by payer), we will aggregate the Medicare and Medicaid per member per month (PMPM) payments to the MediConnect Plan and the costs for the eligible population that is not enrolled in the demonstration, per the intent-to-treat evaluation design. This approach will help us to detect overall cost impact and eliminate the effects of potential selection bias among beneficiaries who participate in the demonstration and those who opt out or disenroll. We will include Part D PMPM and any PMPM reconciliation data provided by CMS in the final assessment of cost impact to ensure that all data are available. Cost savings will be calculated twice for capitated model demonstrations using a regression-based approach. The methodology for determining cost savings for capitated model demonstrations is currently under development and will be reviewed and approved by the CMS Office of the Actuary.

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 California will be asked to provide and evaluation activities in which State staff will participate. As shown in this table, the RTI evaluation team will access claims, encounter, and other administrative data from CMS. These data, and how they will be used in the evaluation, are discussed in detail in this evaluation plan and in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

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

RTI will obtain data from:	Type of data
CMS	• Encounter data (Medicare Advantage, Medicaid, and MediConnect Plan) • HEDIS measures • Results from HOS and CAHPS surveys • Medicare and Medicaid fee-for-service claims • Medicare Part D costs • Nursing facility data (MDS) • CMS-HCC and RXHCC risk scores • Demonstration quality measures that California is required to report to CMS (listed in 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
State	• Detailed description of State's method for identifying eligible beneficiaries • File with monthly information identifying beneficiaries eligible for the demonstration (submitted quarterly)[1] • SDRS (described in detail in Section 4 of the *Aggregate Evaluation Plan*) quarterly submissions of demonstration updates including monthly statistics on enrollments, opt-outs, and disenrollments • Participation in key informant interviews and site visits conducted by RTI team • Results from surveys, focus groups, or other evaluation activities (e.g., EQRO or Ombuds reports) conducted or contracted by the State,[2] if applicable • Other data State 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; MOU = Memorandum of Understanding (MOU, 2013); RXHCC = prescription drug hierarchical condition category; SDRS = State Data Reporting System.

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

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

References

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements. February 21, 2014. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf. As obtained on April 29, 2014.

Centers for Medicare & Medicaid Services (CMS) and State of California: Memorandum of Understanding (MOU) between the Centers for Medicare and Medicaid Services and the State of California Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees. California Demonstration to Integrate Care for Dual Eligible Beneficiaries. March 27, 2013. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/CAMOU.pdf.

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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 (LTSS) for Medicare-Medicaid enrollees, with the expectation that integrated delivery models would address the current challenges associated with the lack of coordination of Medicare and Medicaid benefits, financing, and incentives.

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

This report describes the State-specific Evaluation Plan for the California demonstration, known as Cal MediConnect, as of July 9, 2014. The evaluation activities may be revised if modifications are made to either the Cal MediConnect 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 California 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 (SDRS; 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 California.

1.2 Research Questions

The major research questions of the California 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 California demonstration is based on the contract between CMS, the State, and MediConnect Plans (CMS and State of California, n.d.; hereafter, California three-way contract); the State's Memorandum of Understanding (MOU) with CMS, signed on March 27, 2013 (CMS and State of California, 2013; hereafter, MOU, 2013); California's Dual Eligible Demonstration Request for Solutions (State of California, 2012a); documents posted on the California Department of Health Care Services website (2014) and the State's demonstration website (n.d.); and discussions and e-mail communications with MMCO staff at CMS and the California Department of Health Care Services regarding the California demonstration as of May 1, 2014. The details of the evaluation design are covered in the three major sections that follow:

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

2. California Demonstration

2.1 Demonstration Goals

The goals of the California demonstration are to improve the beneficiary experience in accessing care, to promote person-centered planning, promote independence in the community, assist beneficiaries in getting the right care at the right time and place; and achieve cost savings for California and the Federal government through improvements in care and coordination. Improving the quality of care, reducing health disparities, and meeting beneficiary needs are central goals of this initiative (MOU, 2013, p. 2).

2.2 Summary of Demonstration

Under the Cal MediConnect demonstration, California and CMS will contract with Medicare-Medicaid Plans (MMPs, also called MediConnect Plans), to provide Medicare and Medi-Cal services to full-benefit Medicare-Medicaid enrollees aged 21 or older, with the exception of certain populations listed below. To participate in the demonstration, plans had to meet the State's requirements set forth in the Request for Solutions (State of California, 2012a); CMS requirements outlined in the Medicare Advantage plan application process and in multiple sets of capitated financial alignment model guidance; and pass a joint CMS/State readiness review. MediConnect Plans and their subcontractors will be responsible for delivering and coordinating medical care, behavioral health services, and LTSS to enrollees. Specialty mental health and substance use services, financed and administered by the counties, are not included in the Cal MediConnect demonstration; however, the MediConnect Plans are required to coordinate with those county agencies. The demonstration is offered in 8 of the State's 58 counties: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, Santa Clara, and San Mateo. Enrollees in 6 counties have a choice of at least two plans; beneficiaries in County Organized Health System (COHS) counties (Orange and San Mateo) will be enrolled in the countywide public health plan that serves all Medi-Cal beneficiaries. Plans will be paid a blended, capitated rate covering all Medicare and Medi-Cal services under three-way contracts between the plans, the State, and CMS. The demonstration began April 1, 2014, with opt-in enrollment in Los Angeles, Riverside, San Bernardino, and San Diego counties; and passive enrollment in San Mateo County. Enrollment in Alameda, Orange, and Santa Clara counties will begin no sooner than January 1, 2015 (State of California, 2014b).

Cal MediConnect is part of the State's Coordinated Care Initiative (CCI) under the Bridge to Reform 1115(a) Medicaid Demonstration that will also transition Medicare-Medicaid enrollees into Medi-Cal managed care, include Medicare wraparound benefits, and integrate managed long-term services and supports (MLTSS) into Medi-Cal in the eight demonstration counties. Under the MLTSS requirement of the CCI, nearly all Medi-Cal beneficiaries aged 21 and older, including Medicare-Medicaid enrollees, will be transitioned into a Medi-Cal managed care health plan to receive their Medi-Cal benefits (CMS, 2014).

The following groups are not eligible to enroll in the demonstration: individuals under age 21; those with other private or public health insurance; beneficiaries receiving services through California's regional centers or State developmental centers or intermediate care

facilities for the developmentally disabled; beneficiaries with a share of cost who do not meet share-of-cost requirements; those residing in one of the Veterans' Homes of California or in certain rural zip codes in San Bernardino, Los Angeles, and Riverside counties; or individuals with a diagnosis of end stage renal disease (ESRD) at the time of enrollment who reside in Alameda, Los Angeles, Riverside, San Bernardino, San Diego, or Santa Clara counties (MOU, 2013, p. 8).

Individuals who are eligible to opt into the demonstration, but not to be passively enrolled, include those who reside in certain rural zip codes in San Bernardino County in which only one MediConnect Plan operates; and beneficiaries who are enrolled in a prepaid health plan that is a nonprofit health care services plan with at least 3.5 million enrollees statewide, that owns and operates its own pharmacies. Individuals participating in the following programs are not eligible to enroll in the demonstration; however, they may do so after they have disenrolled from the program: Program of All-Inclusive Care for the Elderly (PACE), the AIDS Healthcare Foundation, or any of the following 1915(c) waivers: Nursing Facility/Acute hospital Waiver, HIV/AIDS Waiver, Assisted Living Waiver, and In Home Operations Waiver (MOU, 2013, p. 9). Beneficiaries enrolled in these 1915(c) waivers are transitioning to managed care under the CCI (State of California, 2013b).

Medicare Advantage enrollees will be eligible for passive enrollment no sooner than January 1, 2015 (State of California, 2014b). All enrollees will retain the right to opt out of the demonstration and receive their Medicare-covered benefits through Medicare fee-for-service or a Medicare Advantage plan; however, they will remain in Medi-Cal managed care. Individuals may switch MediConnect Plans at any time, and beneficiaries who opt out of the demonstration may reenroll at any time. Medicare-Medicaid enrollees will be sent an initial notice that shares general information about Cal MediConnect 90 days before the passive enrollment effective date, followed by an information letter no less than 60 days before the passive enrollment effective date. A third letter, no less than 30 days in advance, informs them of their opportunity to select a MediConnect Plan or opt out of the demonstration before the passive enrollment takes effect. Beneficiaries who fail to respond to the 60- and 30-day letters will be automatically assigned to one of the MediConnect Plans in their county. California will use intelligent assignment to passively enroll beneficiaries into MediConnect Plans by reviewing enrollees' recent service and provider use and enrolling them in plans that most closely fit their needs (MOU, 2013, pp. 63–69). In Los Angeles County, passive enrollment will take place after a 3-month opt-in period that began April 1, 2014; please refer to ***Table 2*** for more information about the county's enrollment plan. Enrollment in Los Angeles County will continue until 200,000 individuals have enrolled, after which a waiting list will be implemented (State of California, 2014a).

After enrollment, a health risk assessment (HRA) will be used to identify primary, acute, behavioral health, LTSS, and functional needs of each enrollee and will be the basis of an individual care plan (ICP). Enrollees identified as higher-risk by the MediConnect Plan's risk-stratification algorithm will be assessed within 45 calendar days of enrollment; all others will be assessed within 90 days (State of California, 2013c). Reassessments will be conducted at least annually, within 12 months of the last assessment, or as often as the health of the enrollee requires. Individual care teams (ICTs) will be formed for each enrollee as needed; enrollees may

also request an ICT. Together with the enrollee, the enrollee's family supports, and providers, the MediConnect Plan care coordinator will develop an ICP that includes all clinical care, behavioral health, and LTSS services, as appropriate. The ICP will be completed within 30 days of HRA completion. LTSS includes care in nursing facilities, home and community-based services, such as In Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) (MOU, 2013, pp. 69–71).

MediConnect Plans are responsible for ensuring that enrollees have seamless coordination and access to all necessary services, including behavioral health services financed and provided by county-based providers. Plans are financially responsible for providing all Medicare behavioral health services; however, Medi-Cal specialty mental health and substance use (Drug Medi-Cal) services, which are financed and administered by counties, are not included in the demonstration's capitated payment to MediConnect Plans. Care coordination by MediConnect Plans will be delineated through Behavioral Health Memoranda of Understanding (BH-MOUs) and contracts with county agencies to ensure seamless delivery of services (MOU, 2013, p. 74). In addition to care coordination, new services that will be added in the demonstration include vision services and nonmedical transportation (MOU, 2013, p. 93). New services available through the CCI, that will be available to all CCI participants including demonstration enrollees, include a new dental benefit through Denti-Cal beginning in May 2014 (State of California, Medi-Cal Dental, n.d.).

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

Table 2
Key features of the California 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	Medi-Cal covered services	Medi-Cal covered services, including institutional care, IHSS, CBAS, MSSP, and additional benefits in lieu of institutionalization.
Payment method (capitated/FFS/MFFS)		
Medicare	Mostly FFS. Some Medicare-Medicaid enrollees are in PACE and D-SNPs.	Capitated
Medicaid (capitated or FFS) Primary/medical	FFS and transitioning to capitated through the CCI.	Capitated

(continued)

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

Key features	Predemonstration	Demonstration[1]
Behavioral health	FFS and transitioning to capitated through the CCI for Medicare and Medi-Cal behavioral health services. FFS for specialty MH and SU services provided by county-administered Medi-Cal Mental Health services (1915[b] waiver services) and Drug Medi-Cal benefits.	Specialty MH and SU services, financed and provided by county-administered Medi-Cal Mental Health services (1915[b] waiver services) and Drug Medi-Cal services, are excluded from the capitated rate. However, MediConnect Plans will coordinate MH and SU services with county-administered agencies per each plan's BH-MOU.
LTSS (excluding HCBS waiver services)	FFS and transitioning to capitated through the CCI: IHSS, skilled nursing facility services, and subacute care services.	Capitated. The demonstration includes the following services: IHSS, skilled nursing facility services, and subacute care services.
HCBS waiver services	FFS and transitioning to capitated through the CCI: CBAS (1115[a] waiver), MSSP, Assisted Living, HIV/AIDS, In Home Operations, and the Nursing Facility/Acute Hospital 1915(c) waivers.	Capitated and includes CBAS, MSSP, and additional benefits in lieu of institutionalization. Other 1915c waiver services are not included in MediConnect.
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	Available only for PACE enrollees and some services in San Mateo and Orange counties. IHSS coordination is provided by the counties.	All enrollees will have access to MediConnect Plan care coordinators who are responsible for coordinating all services.
Care coordination/case management for HCBS waivers and by whom	Available only for the MSSP waiver (nursing facility certifiable population) enrollees.	MediConnect Plan care coordinators will coordinate care for enrollees, including MSSP and CBAS waiver coordination. Other waivers are excluded from demonstration.
TCM	Provided by county-administered agencies to certain individuals with mental illness under the Section 1915(b) "freedom of choice" waiver.	These services are excluded from the capitated rate and will continue to be provided by county-administered agencies. However, MediConnect Plans will coordinate these services with county-administered agencies per each plan's BH-MOU.
Rehabilitation Option services	Same as above (for TCM).	Same as above (for TCM).
Clinical, integrated, or intensive care management	Only for those in PACE.	MediConnect Plans will provide these services to beneficiaries identified as high risk.

(continued)

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

Key features	Predemonstration	Demonstration[1]
Enrollment/assignment		
Enrollment method	All Medicare-Medicaid enrollees in the demonstration counties are transitioning to mandatory Medi-Cal managed care as part of the CCI in 6 counties. Medicare-Medicaid enrollees in the 2 COHS counties will have more MLTSS services added to Medi-Cal managed care.	Enrollment methods are opt-in and passive; enrollment processes are specific to each county (see Phase-in Plan below). A county may have a single effective enrollment date, or there may be passive enrollment phased in by birth date. Medicare-Medicaid enrollees may opt out of the demonstration but will remain enrolled in Medi-Cal managed care.
Attribution/assignment method	N/A	Beneficiaries in 6 demonstration counties may choose from at least 2 MediConnect Plans; those in COHS counties (Orange and San Mateo) will be enrolled in the COHS health plan. If enrollees do not choose a plan, intelligent assignment methodology for passive enrollment will include using claims data to assign enrollees to a MediConnect Plan that includes their current providers.
Implementation		
Geographic area	N/A	Eight counties
Phase-in plan	N/A	● San Mateo County: began 4/1/14 with one wave of passive enrollment for all eligible Medicare-Medicaid enrollees in Medicare FFS. Enrollees in the HPSM D-SNP and those in 2014 LIS reassignment will be passively enrolled 1/1/15. ● Riverside, San Bernardino, and San Diego counties: began 4/1/14 with 1 month of opt-in, followed by passive enrollment, generally by birth month, for 12 months. Beneficiaries in Medi-Cal managed care will be enrolled in the first month of passive enrollment. Beneficiaries in LIS reassignment and beneficiaries in D-SNPs affiliated with MediConnect Plans will be passively enrolled 1/1/15.

(continued)

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

Key features	Predemonstration	Demonstration[1]
Phase-in plan (continued)		• Los Angeles County: began 4/1/14 with a 3- month opt-in period, to be followed by 12 months of passive enrollment by birth month. Beneficiaries in LIS reassignment and beneficiaries in D-SNPs affiliated with MediConnect Plans will be passively enrolled 1/1/15. • Alameda, Orange, and Santa Clara counties: will begin no sooner than 1/1/15; the passive enrollment schedule will be determined at a later date.
Implementation date		4/1/14

BH-MOU = Behavioral Health Memorandum of Understanding; CBAS = Community-Based Adult Services; CCI = Coordinated Care Initiative; COHS = County Organized Health System; DD = developmental disability; D-SNPs = Dual Eligible Special Needs Plans; FFS = fee for service; HCBS = home and community-based services; HPSM = Health Plan of San Mateo; ICT = interdisciplinary care team; IHSS = In-Home Supportive Services; LAC = Los Angeles County; LIS: low-income subsidy; LTSS = long-term services and supports; MA = Medicare Advantage; MFFS = managed fee for service; MH = mental health; MLTSS = managed long-term services and supports; MOU = memorandum of understanding; MSSP = Multipurpose Senior Services Program; N/A = not applicable; PACE = Program of All-Inclusive Care for the Elderly; SU = substance use.

[1] Information related to the demonstration in this table is from the Memorandum of Understanding (MOU, 2013), CCI Enrollment Timeline by County and Population of April 2, 2014, and the CalDuals Enrollment Strategy for Los Angeles County into Cal MediConnect of February 18, 2014; and communication with CMS on May 1, 2014.

As shown in ***Table 3***, the total Medicare and Medi-Cal spending on full- and partial-benefit Medicare-Medicaid enrollees in California in calendar year 2007 was $27 billion. This represents services to about 1.2 million Medicare-Medicaid enrollees, who constitute 26 percent of California's Medicare population and 11 percent of its Medi-Cal population. Figures for spending on the target population for this demonstration (i.e., those who would have been eligible to participate in the demonstration had it been operational) are not available.

Table 3
Total expenditures for Medicare-Medicaid enrollees statewide CY 2007

Population	Medicaid expenditures	Medicare expenditures	Total expenditures
Full- and partial-benefit Medicare-Medicaid enrollee population statewide	$10.4 billion	$16.6 billion	$27 billion

SOURCE: Centers for Medicare &Medicaid Services (CMS), State Profile: California, n.d.

2.3 Relevant Historical and Current Context

History/Experience with Managed Care. California has an established Medi-Cal managed care program, and its contracted health plans have acquired experience in coordinating beneficiaries' services for Medi-Cal. The Department of Health Care Services (DHCS) and the Department of Managed Health Care (DMHC) provide oversight of managed care plans.

Three models of Medi-Cal managed care are in operation:

- **Two-Plan Model.** The Two-Plan Model exists in counties where the DHCS contracts with only two managed care plans. One plan must be locally developed and operated. The second plan is a commercial Health Maintenance Organization (HMO), selected through a competitive bidding process. These plans, in turn, contract with other plans and provider groups to provide services to enrollees. The demonstration counties of San Bernardino, Los Angeles, Riverside, Alameda, and Santa Clara counties have two-plan systems.

- **County Organized Health System (COHS).** Under this model, there is one health plan run by a public agency and governed by an independent board that includes local representatives. In COHS counties, Medi-Cal beneficiaries have been enrolled mandatorily in managed care prior to this demonstration. Over the past 20 years, LTSS have been added to the services package offered by the COHS. The demonstration counties of San Mateo and Orange belong to the COHS system.

- **Geographic Managed Care (GMC).** The GMC system allows Medi-Cal beneficiaries to choose to enroll in one of many commercial HMOs operating in a county. Only one demonstration county, San Diego, belongs to this model (State of California, 2012a).

Some plans in California have experience coordinating Medicare benefits for Medicare-Medicaid enrollees. The majority of California's 1.2 million Medicare-Medicaid enrollees currently receive their benefits on a fee-for-service basis, although there is some dual-eligible special needs plan (D-SNP) penetration (156,000 enrollees) and some special programs that include Medicare-Medicaid enrollees. Eight PACE programs in California operate 24 PACE centers that serve more than 4,000 dual eligible beneficiaries. PACE programs are currently available in four of the eight demonstration counties--Alameda, Santa Clara, Los Angeles, and San Diego--and will continue to operate under the demonstration.

The D-SNPs in California include a former Social HMO, currently operating in three counties and providing LTSS under a contract with the State. Positive Healthcare, a division of the AIDS Healthcare Foundation, jointly enrolls about 800 Medicare-Medicaid beneficiaries in its Medi-Cal Health Plan and its companion Medicare Advantage Chronic Condition SNP (C-SNP) (State of California, 2012a). All participating MediConnect Plans, with the exception of Santa Clara Family Health Plan, had a D-SNP product in place at the beginning of the demonstration. Santa Clara Family Health Plan ended its D-SNP about 2 years ago. CMS currently requires D-SNPs to have contracts that comply with the Medicare Improvement for Patients and Providers Act (MIPPA) of 2008. Under these contracts, California D-SNPs were

authorized through calendar year 2014. Enrollees in Medicare Advantage (MA) products, including D-SNPs, who are eligible for MediConnect, will be passively enrolled into the demonstration effective January 2015. As a result of considerable stakeholder input, a new State policy addressing D-SNP contracts in CCI counties is currently under discussion in the State legislature and is expected to be finalized in July 2014 (State of California, 2014c).

California recently expanded mandatory managed care enrollment for medical services to Medi-Cal-only seniors, Medicare-Medicaid enrollees in COHS counties, and seniors and persons with disabilities (SPDs) in all Medi-Cal managed care counties. This transition, spanning 16 counties and more than 400,000 SPDs, started in June 2011 and was completed in May 2012. Therefore, Medi-Cal plans have experience serving non-Medicare aged and disabled populations. This expansion was part of the California Bridge to Reform 1115(a) Medicaid Demonstration approved in 2010. During this enrollment process, 39 percent of SPDs actively chose a plan and the remaining 61 percent were assigned to a plan (Kaiser Family Foundation, 2011).

California has an established array of home and community-based service (HCBS) programs that include In-Home Supportive Services (IHSS), Community-Based Adult Services (CBAS), Multipurpose Senior Services Program (MSSP), nursing facility care, and subacute care services. The IHSS personal care services program, the largest of the State's HCBS programs, operates within the Department of Social Services. It provides in-home care for people who cannot safely remain in their own homes without assistance; it supports consumer-direction, including the consumer's right to hire, fire, and manage the IHSS provider. Counties provide support for IHSS administrative functions, conduct assessments, and authorize hours for each beneficiary. Under the demonstration, counties will retain their authority, but the payment for the IHSS workers' hours is included in the capitated payment to the MediConnect Plan. With beneficiaries' approval, the IHSS providers will participate in individual care teams that will be convened by the MediConnect Plans' care coordinators. If the MediConnect Plan would provide additional personal care hours, this would be a benefit borne by the plan; it would not be considered a part of the IHSS benefit.

MSSP is a 1915(c) HCBS waiver designed for those aged 65 or older with a nursing facility level of need; it operates within the Department of Aging. Services, provided by county and nonprofit organizations, include care management, respite care, supplemental personal care, adult day care, adult day support center, communication, housing assistance, nutritional services, protective services, purchased care management, supplemental chore, supplemental health care, supplemental professional care assistance, supplemental protective supervision, and transportation. Under the demonstration, current recipients of MSSP case management will be enrolled in the MediConnect Plans and will continue to receive MSSP services. In the first demonstration year, plans will contract with designated MSSP providers to provide case management and waiver services at the same level of funding as under existing MSSP contracts with the California Department of Aging. MediConnect Plans will collaborate with MSSP providers to develop an integrated, person-centered care management model. MSSP services will transition from Federal waiver to a benefit administered and allocated by the Plans in 2016.

Also within the Department of Aging, the CBAS program, formerly named Adult Day Health Care (ADHC), became operational in April 2012 under an 1115(a) waiver. Statewide, it

operates more than 200 centers that are staffed with registered nurses, physical and occupational therapists, social workers, and other trained personal care workers who provide adult day health programs and offer assessment, supervision, and social/recreation services to eligible Medi-Cal beneficiaries, aged 18 years and older. CBAS is an alternative to nursing facility placement for beneficiaries who meet the State's nursing facility level of care requirements, have a developmental disability, have diagnosed cognitive impairment, or are members of the Mental Health Plans (MHPs); the great majority of CBAS clients are Medicare-Medicaid enrollees. Almost half of CBAS participants have a psychiatric diagnosis, and 30 percent are diagnosed with dementia (The SCAN Foundation, December 2013). The CBAS program is available only to beneficiaries enrolled in Medi-Cal managed care, not for those in fee-for-service. Under the demonstration, MediConnect Plans will contract with CBAS centers at the rates set by the DHCS as they currently do for their Medi-Cal managed care product line. Most of these contracts have been in place; new CBAS contracts have been developed recently for three plans in Los Angeles County (Care1st, Blue Cross, and Molina).

Mental Health and Substance Use Services. MediConnect Plans will be responsible for coordinating all services for their enrollees, including services provided by non-network providers. Specialty mental health services and substance use services described below will continue to be provided by the county-based providers during the demonstration.

Specialty mental health services in California are managed and provided through county MHPs through a Section 1915(b) Freedom of Choice waiver. All individuals who meet specified medical necessity criteria are mandatorily enrolled in the State's county MHPs. This waiver program serves an estimated 445,000 individuals statewide; about 27 percent of the 240,000 adults served in MHPs are Medicare-Medicaid enrollees. MHPs select and credential their provider network, negotiate rates, authorize services, and pay for qualifying services. The portion of services provided directly by each MHP's own providers, compared with contracted private providers, varies across counties. The services provided under this waiver include psychiatric inpatient hospital services, targeted case management services, and rehabilitation services, including medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential treatment services, and psychiatric health facility services.

Drug Medi-Cal is California's substance use benefit for Medi-Cal beneficiaries; its benefits include methadone maintenance, day care rehabilitation, outpatient individual and group counseling, and perinatal residential services. Because there is no rehabilitation option for Drug Medi-Cal, it does not cover case management or services outside a clinical setting. Currently, much of Drug Medi-Cal spending on Medicare-Medicaid enrollees supports the methadone maintenance program. The State Department of Drug and Alcohol Programs reimbursed providers directly for Drug Medi-Cal services until 2011, when counties assumed this responsibility (State of California, 2012a).

Recently, the California Health Facilities Financing Authority approved the distribution of about $75 million in grants to boost county mental health community-based services. The measure will increase the number of residential mental health and crisis stabilization beds, add new workers to staff mobile support teams, and provide support vehicles. MHPs in five

MediConnect demonstration counties (Alameda, Los Angeles, Riverside, San Diego, and Santa Clara) will receive additional funding from this source (State of California, 2014d).

Other Initiatives. In January 2007, California initiated its Money Follows the Person Rebalancing Demonstration, "California Community Transitions" (CCT). Lead organizations identify eligible Medi-Cal beneficiaries who have continuously resided in State-licensed health care facilities for a period of at least 90 days and contract with transition coordinators who work directly with willing and eligible individuals, support networks, and providers to facilitate and monitor their transition from facilities to community settings. Eligible individuals of all ages with physical and mental disabilities have an opportunity to participate in CCT services, which will be available through September 30, 2016. Cal MediConnect demonstration enrollees are eligible to participate in the CCT (State of California, 2006; communication with CMS on December 12, 2013).

In 2013, CMS approved a California State Plan Amendment to implement the Community First Choice Option (CFCO), a Medicaid HCBS State Plan option created by Section 2401 of the Affordable Care Act (Patient Protection and Affordable Care Act of 2010). California proposed both an "agency model" and a consumer-directed model for the program; the consumer-directed component builds on California's existing IHSS personal care services and in-home support services program; the agency component is new. Medicaid aged and disabled persons with a nursing-facility level of need may receive personal care services, paramedical services, protective supervision, and other services under the approved plan (State of California, 2013d).

3. Demonstration Implementation Evaluation

3.1 Purpose

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

- What are the primary design features of the California demonstration, and how do they differ from the State's previous system available to the demonstration eligible population?
- To what extent did California 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 California 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 California 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 California demonstration are described using a common framework that RTI will apply to all of the demonstrations under the Financial Alignment Initiative as follows:

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

Our analysis of the implementation of the California demonstration will be organized by these key demonstration design features. This framework will be used to define our areas of inquiry, structure the demonstration variables we track, organize information from our data collection sources, and outline our annual report. ***Table 4*** illustrates the key components of each design feature that we will monitor as part of the implementation evaluation. Our goal is to frame analysis at the level of policy or practice with examples of how the intended design features and their key components translate at the point of service delivery.

Table 4
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)	• MediConnect Plans • Primary care • LTSS • Behavioral health services coordination with county agencies • 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 MediConnect Plan, at provider level or other) • Data (Medicare claims or encounter data) and other feedback to MediConnect Plans, other providers (by the State or other entities) • Primary care practice support (e.g., coaching, learning collaboratives, training)
Care coordination/case management (by subpopulation 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 • Phased enrollment of eligible populations

(continued)

Table 4 (continued)
Demonstration design features and key components

Design feature	Key components
Beneficiary engagement and protections	• Policies to integrate Medicare and Medicaid grievances and appeals • Quality management systems • Beneficiary participation on governing board/committees • Ongoing methods for engaging beneficiary organizations in policy decisions and implementation • Approaches to capture beneficiary experience, such as surveys and focus groups
Demonstration financing model and methods of payment to plans and providers	• Financing model: capitated • Entities to which the State is directly making payments • Innovative payment methods to MediConnect Plans and/or to providers
Elements of payments to MediConnect Plans and providers	• Incentives • Shared savings • Risk adjustment

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

3.4 Implementation Tracking Elements

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

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

During site visit interviews and our ongoing communication with the State, we will collect detailed information on how California has structured care coordination for beneficiaries enrolled in the demonstration. The evaluation will analyze the scope of care coordination responsibilities assigned to MediConnect Plans, the extent to which they conduct these functions directly or through contract, and internal structures established to promote service integration. We will also identify ways that the scope of care coordination activities conducted under the

demonstration by MediConnect Plans compares to the State's approach in its capitated model programs serving other populations.

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

Table 5 shows the types of demonstration implementation elements we will track using State submissions to the SDRS, quarterly calls with State demonstration staff, other interviews, and site visits.

Table 5
Implementation tracking elements by demonstration design feature

Design feature	Tracking elements
Integrated delivery system	• Contracts with MediConnect Plans • Documentation of coordination activities between MediConnect Plans 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., MediConnect Plan-level reporting on QIs) • State efforts to build MediConnect Plan and provider core competencies for serving beneficiaries with various types of disabilities • Provision of regular feedback to MediConnect Plans and providers on the results of their performance measures

(continued)

Table 5 (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 • Requirements for assessment and service planning • Requirements for coordination and integration of clinical, LTSS, and behavioral health services • Approaches to stratify care coordination intensity based on individual needs • 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 plans, practices, fall prevention programs)
Enrollment and access to care	• State efforts to provide integrated consumer information on enrollment, benefits, and choice of MediConnect Plans/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 • Role of Ombuds program • Adoption of new policies for beneficiary grievances and appeals based on demonstration experience
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 records; EMR = electronic medical records; LTSS = long-term services and supports; MHP = Mental Health Plan; QIs = quality improvement initiatives.

3.5 Progress Indicators

In addition to tracking implementation of demonstration design features, we will also track progress indicators, including growth in enrollment and disenrollment patterns, based on California's demonstration data. These progress indicators will be reported quarterly by California 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 California 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 demonstrations as a whole. More detail on the SDRS can be found in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

Table 6 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 6
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 prior to enrollment
No. of beneficiaries who voluntarily disenrolled from the demonstration
No. of beneficiaries whose enrollment in the demonstration ended involuntarily (e.g., died, moved out of area, lost Medicaid eligibility, were incarcerated)
Demonstration service area
Whether demonstration is currently statewide vs. 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 MediConnect Plans

3.6 Data Sources

The evaluation team will use a variety of data sources to assess whether the California 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:

- **State policies and State requirements for provider and plan agreements:** The evaluation team will review a wide range of State-developed documents that specify the approach to implementing the California demonstration in order to develop a baseline profile of its current delivery system. Review of California's agreements with CMS articulated through the demonstration memorandum of understanding (MOU), waivers, contracts, and State Plan Amendments will further enhance our understanding of the California approach.

- **Demonstration data (collected via the State Data Reporting System):** On a quarterly basis, we will collect data from California to inform ongoing analysis and feedback to the State and CMS throughout the demonstration. Specifically, we will collect data to track policy and operational changes and progress indicators that are mostly numeric counts of key demonstration elements presented in ***Table 6***. These demonstration data also may include specific information provided by CMS or other entities engaged in this demonstration, and incorporated into the State Data Reporting System.

- **State agency staff, stakeholders, selected contractors, care coordination organizations, Medicare-Medicaid Plans:** There will be at least two sets of site visits; the first one will occur within 6 months of demonstration implementation. Using two-person teams, supplemented with telephone interviews, we will obtain perspectives from key informants on progress to date, internal and external environmental changes, reasons California took a particular course, and current successes and challenges. In addition to the site visits, and interim calls for clarification about State data submitted to the reporting system, in consultation with CMS we will develop a schedule of quarterly telephone interviews with various individuals involved in the demonstration.

  In addition to consumer advocates, as discussed in ***Section 4.1, Beneficiary Experience***, candidates for key informant interviews on demonstration implementation include, but are not limited to, the following:

  – Representatives from the Cal MediConnect advisory council
  – Representatives from the CCI advisory council
  – Representatives from CMS–State Contract Management Team
  – Representatives from the Cal MediConnect Ombuds program
  – State officials, such as:
    - Director, Department of Health Care Services (DHCS)
    - Chief, Medi-Cal Managed Care Division (MMCD)
    - Chief, Health Care Delivery Systems Division (HCDS)

- Chief, Long-Term Care Division (LTCD)
- Chief, MMCD Program Monitoring and Medicaid Policy Branch
- Director, Department of Social Services (CDSS)
- Director, Department of Aging (CDA)
- Director, Department of Managed Health Care (DMHC)
- Director, Health and Human Services Agency
- Program Coordinators, Medi-Cal Health Plan program
- Finance Manager, Medi-Cal
- Director, Cal MediConnect

– Representatives from the Health Insurance Counseling and Advocacy Program (HICAP)

– Leadership and staff from selected MediConnect Plans in COHS, Two Plan, and Geographic Managed counties

– Leadership and staff from selected county Mental Health Plans

– Representatives from State agencies representing Medicare-Medicaid enrollees, including the Long-Term Care and Aging Services Division of the Department of Aging, the Department of Mental Health, and the Department of Alcohol and Drug Programs.

– Program Directors, CBAS, IHHS, and MSSP

– Representatives from other providers and provider associations

– Director, Area Agency on Aging

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 capitated financial alignment model demonstrations, as well as a few questions that are specific to the California demonstration. Questions will be tailored to the key informants in California. The topic areas to be covered during key informant interviews will be provided to the State in advance of each site visit. The site visit interview protocols with core questions are provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013), and will also be tailored for California after the demonstration begins. In advance of the site visits, the RTI team will contact the State to help identify the appropriate individuals to interview. We will work with the State to schedule the site visit and the on-site interviews. We will develop an interview schedule that best suits the needs of the State and key informants we plan to interview.

3.7 Analytic Methods

Evaluation of the California demonstration implementation will be presented in an initial report to CMS and the State covering the first 6 months of implementation, in annual State-specific evaluation reports, and integrated into annual aggregate reports comparing implementation issues and progress across similar demonstrations and across all demonstrations,

as appropriate. We will collect and report quantitative data quarterly as noted in ***Table 6***, Examples of Progress Indicators, through the State Data Reporting System. We will integrate these quantitative data with qualitative data we will collect through site visits and telephone interviews with State agency staff and other key informants and include these data in the annual reports and the final evaluation report. These data will provide context for interpreting the impact and outcomes related to beneficiary experience, quality, utilization, and costs, and enable us to analyze (1) the changes California has made to the preexisting delivery systems serving Medicare-Medicaid enrollees, (2) challenges California 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 California demonstration on beneficiary experience. Using mixed methods (i.e., qualitative and quantitative approaches), we will monitor and evaluate the experience of beneficiaries, their families, and caregivers. Our methods will include the following:

- the beneficiary voice through focus groups and stakeholder interviews conducted by RTI;
- results of surveys that may be conducted by California, CMS, or other entities (e.g., Consumer Assessment of Healthcare Providers and Systems [CAHPS]);
- California 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 California demonstration staff during site visits or telephone interviews with RTI.

Table 7 (described in more detail below) shows the range of topics and data sources we will use to monitor and evaluate beneficiary experience. We are interested in the perspective of the beneficiaries themselves, determining specifically the impact of the demonstration on their access to needed services, the integration and coordination of services across settings and delivery systems, provider choice, enrollee rights and protections, and the provision of person-centered care. In the process, we will identify what has changed for beneficiaries since their enrollment in the demonstration and its perceived impact on their health and well-being.

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

Through beneficiary focus groups and key stakeholder interviews (i.e., consumer and advocacy group members), we also will explore whether we can identify specific demonstration features in California that may influence replication in other States. We will also collect information from State demonstration staff and CMS or other entities that reflects the beneficiaries' experiences (e.g., grievances and appeals, disenrollment patterns) using RTI's

State Data Reporting System. ***Section 3, Demonstration Implementation Evaluation***, describes topics we will monitor and document through interviews with California demonstration staff and document reviews, including consumer protections and other demonstration design features intended to enhance the beneficiary experience. Refer to ***Section 4.2*** for a discussion of the use of claims and encounter data to establish baseline information about the beneficiaries eligible for the demonstration, and how we will use these data to inform our understanding of the impact of the demonstration on access to care and health outcomes.

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

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

Our framework for evaluating beneficiary experience is influenced by work conducted by the Center for Health Care Strategies (CHCS), which identified the essential elements of integration affecting beneficiary experience, including the care process and quality of life (Lind and Gore, 2010). Its work is intended to guide the design of integrated care systems for Medicare-Medicaid enrollees and to do so in ways that strengthen the beneficiary experience in the areas defined in ***Table 7***.

Table 7
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	California demonstration data[2]	Interviews with California 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 7 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	California demonstration data[2]	Interviews with California 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 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 7 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	California demonstration data[2]	Interviews with California 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 7 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	California demonstration data[2]	Interviews with California 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 7 (continued)
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	California demonstration data[2]	Interviews with California 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 7 (continued)
Methods for assessing beneficiary experience by beneficiary impact

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

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

[1] The evaluation team will recommend questions to add to surveys conducted by California or CMS.

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

Table 7 aligns key elements identified in the CHCS framework with the demonstration design features described in ***Section 3, Demonstration Implementation Evaluation***. We modified some elements of the CHCS framework to reflect that not all Medicare-Medicaid enrollees require intensive services as suggested by the original CHCS language used when describing comprehensive assessments and multidisciplinary care teams. For each key element, we identify the impact on beneficiary experience and detail the data sources that RTI will use to obtain the information.

As shown in ***Table 7***, we will solicit direct feedback from beneficiaries served through the demonstration to determine how closely their experience compares to the desired outcomes (improvements in personal health outcomes, quality of life, how beneficiaries seek care, choice of care options, and how care is delivered). We will include topics specific to the demonstration and supplement our understanding of direct beneficiary experience with key stakeholder interviews (e.g., consumer and advocacy groups), a review of enrollment and disenrollment, grievances and appeals, claims and encounter data analysis, and interviews with California staff on demonstration implementation.

Table 8 highlights some of the quantitative measures of beneficiary experience we will monitor and evaluate using demonstration statistics and claims or encounter data analysis. See ***Section 4.2*** for a discussion of the quality, utilization, and access to care measures we plan to examine as part of the overall evaluation of impact of the California demonstration on beneficiary outcomes, including for subpopulations. The draft focus group protocol and the draft stakeholder interview protocol are both discussed in this section and are available in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

We will analyze our findings by subpopulation. We will identify the subpopulations of particular interest for California and, where possible, will recruit sufficient numbers of individuals in those subpopulations to participate in the focus groups. We will analyze our focus group findings about beneficiary experience to determine whether differences exist by subpopulation.

Table 8
Demonstration statistics on quality, utilization, and access to care measures of beneficiary experience

Rate of auto-assignment to MediConnect Plans (if available)
Rate of disenrollment from the demonstration by reason[1]
Rate of beneficiaries who opt out of enrolling into demonstration
Number and type of beneficiary complaints, grievance, 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

We will rely on five major data sources to assess beneficiary experience as shown in ***Table 7***. In this section we describe our plan for using focus group and stakeholder interviews; results of beneficiary surveys planned by the State, CMS, or other entities (e.g., CAHPS); State demonstration data entered into the State Data Reporting System; and interviews with State demonstration staff.

4.1.3.1 Focus Groups

We will conduct four focus groups in California to gain insight into how the initiative affects beneficiaries. To ensure that we capture the direct experience and observations of those served by the California demonstration, focus groups will be limited to demonstration enrollees, their family members, and informal caregivers. ***Table 9*** shows our current plan for the composition and number of focus groups.

We are aware that California may consider conducting its own focus groups during demonstration implementation. If California, or other entities, should decide to conduct focus groups and share their results with RTI, we will use findings from those activities to inform the content or composition of our focus groups. Preliminary topics of the focus groups include beneficiaries' understanding of the demonstration, rights, options, and choices (e.g., plan, primary care provider); reasons beneficiaries choose to enroll and disenroll; their benefits; concerns or problems encountered; experience with care coordination; and access to primary and specialty care, and LTSS. Timing for conducting the focus groups will be influenced by our assessment of whether there is more to be learned about the experience of beneficiaries shortly after initial enrollment into the California demonstration versus their perceptions of its effectiveness later in the California demonstration. If the latter, we will conduct focus groups at least 1 year after implementation so that beneficiaries have had a substantial amount of experience with the demonstration. We will make the decision regarding timing of the focus groups in conjunction with CMS.

Table 9
Purpose and scope of State focus groups

Primary purpose	To understand beneficiary experience with the demonstration and, where possible, to identify factors and design features contributing to their experience.
Composition	Each focus group includes 8–10 individuals who may be beneficiaries or family members or caregivers representing beneficiaries. These may include but are not limited to beneficiaries with the following: ● high LTSS needs ● low LTSS needs ● physical disabilities ● behavioral health needs
Number	Four focus groups

LTSS = long-term services and supports.

We will recruit focus group participants from eligibility and enrollment files independent of input from the State. In doing so, we will identify beneficiaries reflecting a range of eligibility, clinical, and demographic characteristics enrolled in the California demonstration. Our subcontractor, the Henne Group, will use a structured approach for screening potential participants and obtaining their agreement to participate. If there appear to be high rates of opting out or disenrollment from the demonstration in California, we will consider convening focus groups with beneficiaries who have chosen to opt out or disenroll to understand their decisions. We will work closely with California 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 subpopulations of concern in California. Given the prevalence of non-English–speaking beneficiaries among the eligible population in California, we plan to conduct some of the focus groups in languages other than English. A preliminary focus group protocol is presented in the *Aggregate Evaluation Plan* (Walsh et al., 2013). The protocol may be modified based on final decisions about focus group composition, content, and our understanding of issues raised during implementation of the California demonstration.

4.1.3.2 Key Stakeholder Interviews

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

Table 10 identifies potential groups in California whose representatives we may wish to interview and the overall purpose of the interview. We will finalize the list of key stakeholders following discussions with demonstration staff in California, a review of events and issues raised during the development and early implementation of the demonstration, and the composition of enrollment by subpopulations.

Table 10
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.
Subpopulations	Interviews will be held with consumer and advocacy groups whose members are served by the California demonstration. These may include the following: ● Beneficiaries serving on Medi-Cal Consumer Advisory Committees ● Beneficiaries serving on MediConnect Advisory Committee or stakeholder groups ● Beneficiaries serving on MediConnect Plan local governing boards ● California Foundation for Independent Living Centers ● California Association of Public Authorities or California State Association of Counties ● California Collaborative ● California Pan-Ethnic Health Network ● Congress of California Seniors ● Disability Rights California ● Personal Assistance Services Council
Number and frequency	**Baseline**: Up to eight telephone interviews within 6 months after implementation. **Throughout demonstration**: Up to eight telephone or in-person interviews in California each year to be conducted with the same individuals each time, unless other stakeholders or topics of interest are identified. **Final year**: Up to eight telephone or in-person interviews.

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

4.1.3.3 Beneficiary Surveys

The RTI evaluation team will not directly administer any beneficiary surveys as part of the evaluation, and we are not requiring that States administer beneficiary surveys for purposes of the evaluation. We will include relevant findings from beneficiary surveys already being conducted for this demonstration by California, CMS, or other entities. As part of CMS requirements for capitated model plans, MediConnect Plans will be required to conduct the Health Outcomes Survey (HOS) and CAHPS. The Medicare HOS and CAHPS surveys will be sampled at the MediConnect Plan level, allowing cross-plan and aggregate comparisons, where appropriate. We will recommend standard questions for inclusion in surveys across all demonstrations under the Financial Alignment Initiative, such as quality of life measures. We will participate in discussions with the State and CMS (and other CMS contractors, as appropriate) regarding content and sampling issues**.** Topics on which we will recommend common questions across demonstrations are shown in ***Table 7***.

4.1.3.4 Demonstration Data

We will use data about the demonstration that we collect from California during site visits, from reports and other materials developed by the State, through the State Data Reporting System, 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 (PCP) 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 subpopulations.

In addition, California plans to monitor quality using a selection of national measures (MOU, 2013, pp. 108–115). To the extent relevant, we will use findings from these State-specific metrics to augment our assessment of beneficiary experience and outcomes in California.

4.1.3.5 Interviews with California Demonstration Staff

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

4.1.4 Analytic Methods

Our analysis will assess beneficiary experience and determine, where possible, how it is affected by financial model and demonstration design features. We also want to examine whether and how beneficiary experience varies by subpopulations. 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 California and compare and contrast those themes by subpopulation within and across States. Because California is implementing a capitated financial alignment model demonstration, we are interested in comparing California's findings with those of capitated model demonstrations in other States, and in determining whether particular design features in this demonstration are likely to affect beneficiary experience.

Most demonstration data will be collected and tracked through the State Data Reporting System. We will also request summary statistics and reports from California, 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 we will focus in evaluating the California 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 California demonstration have on utilization patterns in acute, long-term, and behavioral health services, overall and for beneficiary subgroups?
- What impact does the California demonstration have on health care quality overall and for beneficiary subgroups?
- Does the California demonstration change access to care for medical, behavioral health, long-term services and supports (LTSS) overall and for beneficiary subgroups? If so, how?
- What impact does the California demonstration have on cost and is there evidence of cost savings? How long did it take to observe cost savings? How were these savings achieved?

In this section, we discuss our approach to identifying the eligible population for California 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 California demonstration. Results of descriptive analyses focusing on differences across years and important subgroups on key outcome variables will be included in the California 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 California 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, beneficiaries already enrolled in a Medicare Advantage plan, a Program of All Inclusive Care for the Elderly (PACE), and several 1915(c) waiver programs 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. To limit selection bias in the evaluation of this demonstration, we will use an intent-to-treat design. This design will address potential selection issues by including the entire population of beneficiaries eligible for the California demonstration, regardless of whether they enroll in the demonstration or actively engage with the MediConnect Plans.

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 MediConnect Plans; 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 those who enroll in the MediConnect Plans with those 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 California will include full-benefit Medicare-Medicaid enrollees aged 21 and above in eight counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara). Ineligible for enrollment are beneficiaries who have other comprehensive insurance plans, receive care in intermediate care facilities for the developmentally disabled or in Veterans' Homes of California, and beneficiaries living in 16 zip codes designated as rural in three of the demonstration counties. Beneficiaries with end stage renal disease are eligible for enrollment only in Orange and San Mateo counties. To analyze quality, utilization, and costs in the predemonstration period, and throughout the demonstration period, California 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 Medi-Cal data, and information about the enrollees eligible for and/or enrolled in the demonstration (***Table 11***). The file will list all of the Medicare-Medicaid beneficiaries eligible for the demonstration, with additional variables 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 Medi-Cal data. RTI will notify the State about the file's design and the method and timing of transmission after the start of the demonstration.

Table 11
State demonstration evaluation (finder) file data fields

Data field	Length	Format	Valid value	Description
Medicare Beneficiary Claim Account Number (Health Insurance Claim Number [HICN])	11	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.
Risk rating category	1	CHAR	Numeric	Coded 1 if institutionalized, 2 if HCBS high, 3 if HCBS low, 4 if community well.

HCBS = home and community-based services; 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 California does not intend to implement statewide, RTI will consider an in-State comparison group. If, however, the areas that will not be included in the demonstration are not sufficiently similar to the demonstration areas, or there are not enough Medicare-Medicaid

enrollee in those areas, we will consider using beneficiaries from both within California and from out of California Metropolitan Statistical Areas (MSAs) similar to the demonstration areas.

We will use statistical distance analysis to identify potential comparison areas in California that are most similar to the demonstration regions in regard to costs, care delivery arrangements, State policy affecting Medicare-Medicaid enrollees, population density, and the supply of medical resources. The specific measures for the statistical distance analysis we will use are Medicare spending per Medicare-Medicaid enrollee, Medicaid spending per Medicare-Medicaid enrollee, nursing facility users per 65-and-over Medicaid beneficiary, 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 primary 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 State policy is most easily visible in the population using the most LTSS (i.e., those aged 65 and over). The relative importance of institutional care observed in that population is expected to affect such use in the population under age 65 as well.

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

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 are as much like demonstration group members as possible, and sufficient data are needed to identify and control for differences.

2. **Sample size:** Because an in-State comparison group is being considered, it will be important to ensure sufficient sample size for the statewide analyses and for analyses of smaller subpopulations. If the sample size is not sufficient, we will consider adding out-of-State comparison areas identified using the statistical distance analysis described above.

3. **Accounting for enrollment in other demonstrations:** Some Medicare-Medicaid enrollees may not be suitable for comparison group selection because of participation

in other demonstrations or enrollment in Accountable Care Organizations. We will work with CMS to specify these parameters and apply them to both California 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 MSIS data submissions will need to be considered if out-of-State comparison areas are required for the evaluation.

4.2.2.4 Propensity Score Framework for Identifying Comparison Group Members

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

The propensity scores for the comparison group will then be weighted so that the distribution of characteristics of the comparison group is similar to that of the demonstration group. By weighting comparison group members' propensity scores, the demonstration and comparison group samples will be more balanced. More detail on this process is provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

4.2.3 Data Sources

Table 12 provides an overview of the data sources to be used in the California evaluation of quality, utilization, and cost. Data sources include Medicare and Medicaid fee-for-service data, Medicare Advantage encounter data, and MediConnect Plan encounter data. These data will be used to examine quality, utilization, and cost in the predemonstration period and during the demonstration. Data will be needed for all beneficiaries enrolled in the demonstration as well as other beneficiaries in the eligible population who do not enroll. Note that data requirements for individual beneficiaries will depend on whether they were in Medicare fee-for-service or Medicare Advantage in the pre- and post-demonstration periods.

The terms of the California 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.

Table 12
Data sources to be used in the California 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 prior to the demonstration; and for comparison groups that may be in-State and/or out-of-State.	Medicaid claims and enrollment data will include data on patient characteristics, beneficiary utilization, and cost of services. Eligibility files will be used to examine changes in number and composition of Medicare-Medicaid enrollees. Will also need these data for beneficiaries who opt out of the demonstration, have disenrolled, or do not enroll for other reasons; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups.	Pre- and post-period beneficiary encounter data (including Medicare Advantage, MediConnect Plan, 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 Medi-Cal data files). Will be used to evaluate quality (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 prior to 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) • Medi-Cal eligibility files	Data will be collected from the following: • CMS • Medicare enrollment data

(continued)

Table 12 (continued)
Data sources to be used in the California 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 prior to the demonstration period (NCH Standard Analytic File). Evaluation file = all demonstration years (NCH TAP Files).	Baseline file = 2 years prior to the demonstration period. Evaluation file = all demonstration years.	Baseline file = Medicare Advantage plans submit encounter data to CMS as of January 1, 2012. RTI will determine to what extent these data can be used in the baseline file. Evaluation file = Medicare Advantage and MediConnect Plans are required to submit encounter data to CMS for all demonstration years.
Potential concerns	—	Expect significant time delay for all Medi-Cal data.	CMS will provide the project team with data under new Medicare Advantage requirements. Any lags in data availability are unknown at this time.

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

[1] Encounter data from Medicare Advantage (MA) or Program of All-Inclusive Care of 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 Medicare Advantage or PACE plans and the demonstration throughout implementation, which we will need to take into account using Medicare Advantage 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 (HIPAA) 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 (DUA) 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 California 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 California demonstration (as data are available);

2. a descriptive analysis of quality, utilization, and cost measures for annual reports with means and comparisons for subgroups of interest, including comparison group results; and

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

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

The approach to each of these analyses is outlined below in ***Table 13,*** and more detail is provided in the *Aggregate Evaluation Design Report* (Walsh et al., 2013). 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 and Medicare Advantage encounter data, MediConnect Plan encounter data, MSIS files, or other data provided by California via the State Data Reporting System will be analyzed quarterly to calculate means, counts, and proportions on selected quality, utilization, and cost measures common across States, depending on availability. Examples of measures that may be included in these quarterly reports to CMS include rates of inpatient admissions, emergency room visits, long-term nursing facility admission, cost per member per month, and all-cause hospital readmission and mortality. We will present the current value for each quarter and the predemonstration period value for each outcome to look at trends over time.

The goal of these analyses is to monitor and track changes in quality, utilization, and costs. Though quarterly analyses will not be multivariate or include comparison group data, these monitoring data will provide valuable, ongoing information on trends occurring during the demonstration period. Various inpatient and emergency room measures that can be reported are described in more detail in our section on quality measures.

Table 13
Quantitative analyses to be performed for California demonstration

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

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

4.3.2 Descriptive Analysis on Quality, Utilization, and Cost Measures

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

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

Consistent with the intent-to-treat approach, all individuals eligible to participate in the demonstration will be included in the analysis, regardless of whether they opt out of the demonstration or disenroll, or actively engage in the MediConnect Plan. Data will be developed for demonstration and comparison group beneficiaries for a 2-year predemonstration period and for each of the years of the demonstration. Predemonstration period data will include

beneficiaries who would have been eligible for the demonstration in the predemonstration period. The starting date for California will be based on the State's implementation date and, therefore, may represent a "performance period," not necessarily a calendar year. The State plans to phase in enrollment differently in each county based on a variety of factors, including county of residence, month of birth, current enrollment in a Medi-Cal managed care plan or in a Medicare Advantage plan (see ***Table 2*** of this report for more detail). To determine whether the experience of those who passively enroll differs from that of those who opt in, we will develop a set of indicators defining monthly eligibility for the various opt-in and passive enrollment pathways. For those beneficiaries with shorter enrollment periods, because of beneficiary death or change of residence, for example, the analysis will weight their experience by months of enrollment within a performance period.

We will measure predemonstration and annual utilization rates and 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. We will calculate average use rates and costs at predemonstration and for each demonstration period. Use rates will be stratified by the State's risk categories (institutionalized, HCBS high, HCBS low, community well) if these designations are provided by the State in the finder file; and by hierarchical condition category (HCC) scores, which are derived from models predicting annual Medicare spending based on claim-based diagnoses in a prior year of claims where higher scores are predictive of higher spending, health status measures, or similar measures. We will adjust for hospitalizations in the prior year using categorical HCC scores or similar measures. Chi-square and *t*-tests will be used to test for significant differences in use across years and between subpopulations such as those receiving long-term services and supports 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, we will use data collected for the eligible population in California 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 Subpopulation Analyses

We will investigate the feasibility of tracking information by subpopulation after the demonstration and comparison groups are identified. For subpopulations of focus in the California demonstration, we will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and behavioral health services, and also examine qualitative data gathered through interviews, focus groups, and surveys. RTI will

compare the characteristics of those who enroll with those 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 subpopulations (e.g., those using and not using behavioral health services, LTSS). Multivariate analyses performed for the final evaluation will account for differential effects for subpopulations in specification testing by using dummy variables for each of the specific subpopulations 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. Because Los Angeles County is distinct from the other demonstration counties in many ways, and because it will probably contain a sufficiently large number of beneficiaries, RTI will also produce descriptive results specific to that county.

4.4 Utilization and Access to Care

Medicare, Medicaid, and MediConnect Plan encounter data will be used to evaluate changes in the levels and types of services used, ranging along a continuum from institutional care to care provided at home (***Table 14***). Note that ***Table 14*** 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 14
Service categories and associated data sources for reporting utilization measures

Service type	Encounter data (Medicare Advantage, MediConnect Plan, and Medicaid MCO)	Medicaid (Medi-Cal) 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 treatment)	X	X	—
Home health	X	—	X
HCBS (PAS, waiver services)	X	X	—
Dental	X	X	—

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

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

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

We anticipate being able to develop traditional utilization measures for each of the service classes in ***Table 14*** (e.g., various inpatient use rates based on diagnoses of interest); however, as of this writing, the timing and availability of MediConnect Plan encounter data are in the process of being finalized. RTI will continue to work closely with CMS to understand how these data can best be utilized by the evaluation.

The treatment of behavioral health services in California's Medi-Cal system affects our ability to fully characterize utilization patterns. Behavioral health services utilization and cost data are not consistently available as part of MSIS because the county service data are maintained in a separate system that is not readily available or easily linkable to MSIS data. Without a complete set of behavioral services data, it will be impossible to fully evaluate demonstration outcomes related to behavioral health and to see whether the demonstration had an effect on utilization patterns.

4.5 Quality of Care

Across all States 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 15***; and information collected by California, CMS, or others and provided in aggregate to the RTI team for inclusion in reports. The latter may include HEDIS measures collected as part of health plan performance, other data that the California MediConnect Plans are required to report, and any beneficiary survey data collected by California, CMS, or other entities (e.g., CAHPS). CMS and California have also identified a set of quality measures that will determine the amount of quality withhold payments (i.e., MediConnect Plans must meet quality standards to earn back a withheld portion of their capitated payments). The quality withhold measures, listed in the California three-way contract, include some measures noted in this report, as well as additional measures. RTI expects to have access to the aggregated results of these additional measures and will include them in the evaluation as feasible and appropriate, understanding that these data are not available for the predemonstration period or for the comparison group. RTI and CMS have developed the core set of evaluation measures for use across State demonstrations; the evaluation will also include a few measures specific to California.

Table 15 provides a working list of the core quality measures to be included in the evaluation of the California 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 California demonstration. We will finalize State-specific quality measures that RTI will identify for the evaluation within the first year of implementation.

Many of the measures in ***Table 15*** are established HEDIS measures that demonstration plans are required to report. The National Committee for Quality Assurance (NCQA) definitions are established and standardized. Given that these data will not be available for those who opt out or disenroll or for comparison populations, we will collect and present the results for each relevant demonstration period.

Table 15
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 15 (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 15 (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 15 (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 15 (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 15 (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 dependent 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.
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).

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Table 15 (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
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 15 (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 15 (continued)
Evaluation quality measures: Detailed definitions, use, and specifications

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

ACE = angiotensin-converting-enzyme; ACSC = ambulatory care-sensitive conditions; AMI = acute myocardial infarction; ARB = Angiotensin II receptor blockers; BMI = body mass index; BP = blood pressure; CABG = coronary artery bypass graft; CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; CVA= cerebrovascular accident; ED = emergency department; 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; 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 7/9/14.

The unique features of California's planned demonstration suggest areas of special focus in quality of care analyses. Of special interest is the integration of behavioral and physical health services and the integration of In-Home Supportive Services (IHSS). Our analyses will pay particular attention to the types of care the State identifies as sensitive to integration. The California demonstration requires that MediConnect Plans coordinate with county behavioral health and IHSS agencies to ensure appropriate access to services for their members, and the State has developed process and outcome measures of shared accountability for these services. Our analysis will seek to include those measures in tracking, and although it will be impossible to fully re-create the State's process measures in the predemonstration period without access to behavioral health or IHSS encounter data, we may be able to replicate some outcome measures (e.g., emergency department use among people using mental health services) as long as some indication exists in the predemonstration period of contact with behavioral health providers.

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, behavioral health conditions). We will continue to work with CMS and the State to identify measures relevant to California and will work to develop specifications for these measures.

4.6 Cost

To determine annual total costs (overall and by payer), we will aggregate the Medicare and Medi-Cal per member per month (PMPM) payments paid to the MediConnect Plans, 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. We will include Part D PMPM and any PMPM reconciliation data provided by CMS in the final assessment of cost impact to ensure that all data are available.

The evaluation will analyze cost data for the service types shown in ***Table 13*** in the previous section on utilization with the addition of prescription drug costs. As with quality and utilization analyses, the descriptive and impact analyses presented in the annual report will include a comparison group. We will present results for important subgroups, and in more detail to better understand their demonstration experience. We will also create a high-cost-user category and track costs of this group over time. To do this, we will measure the percentage of beneficiaries defined as high cost in Year 1 (e.g., those beneficiaries in the top 10 percent of costs). In subsequent years we will look at the percentage of beneficiaries above the Year 1 threshold to learn more about potential success in managing the costs of high-cost beneficiaries as a result of the demonstration.

We will also evaluate cost savings for capitated model demonstrations twice during the demonstration using a regression-based approach and the comparison group described in ***Section 4.2.2*** of this report. The methodology for evaluating cost savings for capitated model demonstrations is currently under development and will be reviewed and approved by the CMS Office of the Actuary. If data are available, we will also estimate cost savings accruing to the Medicare and Medicaid programs separately.

4.7 Analytic Challenges

Obtaining Medi-Cal fee-for-service data for the predemonstration and demonstration periods and MediConnect Plan encounter data for the demonstration period will be critical for the evaluation. The MediConnect Plan encounter data are necessary to measure quality, utilization, and costs. It will be important for California to submit Medi-Cal fee-for-service data in a timely manner. It will also be important for CMS to continue to work with other States that may serve as comparison groups to update and maintain their MSIS/t-MSIS submissions. Because the timing and availability of MediConnect Plan encounter data are still being finalized, RTI will continue to work closely with CMS to understand how these data can best be utilized by the evaluation. Other analytic challenges will include addressing financing issues, including upper payment limits (UPLs), provider taxes, and disproportionate share hospital (DSH) payments as well as possible State policy changes during 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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