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

Rhode Island Draft Evaluation Design Plan

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

RHODE ISLAND DRAFT EVALUATION DESIGN PLAN VERSION 3.0

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Glossary of Rhode Island Acronyms

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

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

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Executive Summary

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

CMS contracted with RTI International to monitor the implementation of all State demonstrations under the Financial Alignment Initiative, and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and State-specific evaluations. This report describes the State-specific evaluation plan for the Rhode Island demonstration.The evaluation activities may be revised if modifications are made either to the Rhode Island demonstration or to the activities described in the *Aggregate Evaluation Plan* (Walsh et al., 2013). Although this document will not be revised to address all changes that may occur, the annual and final evaluation reports will note areas where the evaluation as executed differs from this evaluation plan.

The goals of the evaluation are to monitor demonstration implementation, evaluate the impact of the demonstration on beneficiary experience, monitor unintended consequences, and monitor and evaluate the demonstration's impact on a range of outcomes for the eligible population as a whole and for special populations (e.g., people with mental illness and/or substance use disorders and LTSS recipients). To achieve these goals, RTI will collect qualitative and quantitative data from Rhode Island each quarter; analyze Medicare and Medicaid enrollment and claims data; conduct site visits, beneficiary focus groups, and key informant interviews; and incorporate relevant findings from any beneficiary surveys conducted by other entities. Information from monitoring and evaluation activities will be reported in a 6-month initial implementation report to CMS and the State, quarterly monitoring reports provided to CMS and the State, annual reports, and a final evaluation report. The key research questions and data sources for each are summarized in ***Table ES-1***.

The principal focus of the evaluation will be at the demonstration level. CMS has engaged an operations support contractor to monitor fulfillment of the demonstration requirements outlined in the Memorandum of Understanding and three-way contracts, including MMP-level monitoring. RTI will integrate that information into the evaluation as appropriate.

Table ES-1
Research questions and data sources

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

— = not applicable.

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

Demonstration Implementation. Evaluation of demonstration implementation will be based on case study methods and quantitative data analysis of enrollment patterns. The RTI evaluation team will monitor progress and revisions to the demonstration, and will identify transferable lessons from the Rhode Island demonstration through the following: document review, ongoing submissions by the State through an online State Data Reporting System (e.g., enrollment and disenrollment statistics and qualitative updates on key aspects of

implementation), quarterly key informant telephone interviews, and at least two sets of site visits. We will also monitor and evaluate several demonstration design features, including progress in developing an integrated delivery system, integrated delivery system supports, care coordination/case management, benefits and services, enrollment and access to care, beneficiary engagement and protections, financing, and payment elements. ***Table 6*** in ***Section 3*** of this report provides a list of the implementation tracking elements that the RTI evaluation team will monitor for each design feature. Examples of tracking elements include State efforts to build plan and provider core competencies for serving beneficiaries with various disability types; State requirements for coordination and integration of clinical, LTSS, and behavioral health services; documentation of coordination activities between the MMP and community-based organizations; phase-in of new or enhanced benefits, and methods to communicate them to eligible populations; and strategies for expanding beneficiary access to demonstration benefits.

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

Beneficiary Experience. The impact of this demonstration on beneficiary experience is an important focus of the evaluation. RTI's framework for evaluating beneficiary experience is influenced by work conducted by the Center for Health Care Strategies (CHCS) on the elements of integration that directly affect beneficiary experience for Medicare-Medicaid enrollees. ***Table 8*** in ***Section 4*** aligns key elements identified in the CHCS framework with the demonstration design features listed in the demonstration implementation section of this report. The goals of these analyses are to examine the beneficiary experience and how it varies by special population, and whether the demonstration has had the desired impact on beneficiary outcomes, including quality of life.

To understand beneficiary experience, the RTI evaluation team will monitor State-reported data quarterly (e.g., reports of beneficiary engagement activities), and discuss issues related to the beneficiary experience during quarterly telephone follow-up calls and site visits with the State and with stakeholders. The team will also obtain data on grievances and appeals from CMS and, as available, other sources. Focus groups will include Medicare-Medicaid enrollees from a variety of special populations, such as racial, ethnic, and linguistic minorities, people with mental health conditions, substance use disorders, LTSS needs, and multiple chronic conditions. Relevant demonstration statistics will be monitored quarterly, and quantitative and qualitative analyses of the beneficiary experience will be included in annual State-specific reports and the final evaluation report.

Analysis Overview. Quality, utilization, access to care, and cost will be monitored and evaluated using encounter, claims, and enrollment data for a 2-year predemonstration period and during the course of the demonstration. The evaluation will use an intent-to-treat (ITT) approach for the quantitative analyses, comparing the eligible population for the Rhode Island demonstration with a similar population that is not affected by the demonstration (i.e., a comparison group). Under the ITT framework, outcome analyses will include all beneficiaries eligible for the demonstration in the demonstration area, including those who opt out, participate but then disenroll, and those who enroll but do not engage with the MMP, and a group of similar individuals in the comparison group. This approach diminishes the potential for selection bias

and highlights the effect of the demonstration on all beneficiaries in the demonstration-eligible population. In addition, RTI will compare the characteristics of those who enroll with those who are eligible but do not enroll and conduct analyses to further explore demonstration effects on demonstration enrollees, acknowledging that selection bias must be taken into account in interpreting the results.

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

Identifying the comparison group members will entail two steps: (1) selecting the geographic area from which the comparison group will be drawn and (2) identifying the individuals who will be included in the comparison group. Because Rhode Island intends to implement its demonstration statewide, RTI will most likely identify a comparison group from out-of-State Metropolitan Statistical Areas. The RTI team will use statistical distance analysis to identify potential comparison areas that are most similar to Rhode Island in regard to costs, care delivery arrangements, and policy affecting Medicare-Medicaid enrollees.

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

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

Analyses. Analyses of quality, utilization, and cost in the Rhode Island evaluation will consist of the following:

1. A monitoring analysis to track quarterly changes in selected quality, utilization, and cost measures over the course of the Rhode Island demonstration.

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

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

4. A calculation of savings twice during the demonstration. RTI has developed the methodology for evaluating savings for States implementing capitated model demonstrations, which will include an analysis of spending by program (including Medicaid and Medicare Parts A and B services).

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

Utilization and Access to Care. Medicare, Medicaid, and MMP encounter data will be used to evaluate changes in the levels and types of services used, ranging along a continuum from institutional care to care provided at home and including changes in the percentage of enrollees receiving supports in the community or who reside in institutional settings (see ***Table 15*** of this report for more detail).

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

- Additional quality measures specific to Rhode Island that RTI may identify for the evaluation. These measures will also be available through claims and encounter data that RTI will obtain from CMS and will not require additional State reporting. These measures will be finalized within the first year of implementation.

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

- Healthcare Effectiveness Data and Information Set measures that MMPs are required to submit, as outlined in the Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements (CMS, 2014).

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

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

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

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

RTI will obtain data from:	Type of data
CMS	▪ Encounter data (Medicare Advantage, Medicaid, and MMP) ▪ HEDIS measures ▪ Results from CAHPS survey and HOS ▪ Medicare and Medicaid fee-for-service claims ▪ Medicare Part D costs[1] ▪ Nursing facility data (MDS) ▪ CMS-HCC and RXHCC risk scores ▪ Demonstration quality measures that Rhode Island is required to report to CMS (listed in the MOU) ▪ Demonstration reporting measures that health plans are required to report to CMS (listed in three-way contracts or other guidance) ▪ Other administrative data as available

(continued)

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

RTI will obtain data from:	Type of data
State	▪ Detailed description of Rhode Island's method for identifying eligible beneficiaries ▪ File with monthly information identifying beneficiaries eligible for the demonstration (can be submitted quarterly)[2] ▪ SDRS (described in detail in Section 4 of the *Aggregate Evaluation Plan*) quarterly submissions of demonstration updates including monthly statistics on enrollments, opt-outs, and disenrollments ▪ Participation in key informant interviews and site visits conducted by the RTI team ▪ Results from surveys, focus groups, or other evaluation activities (e.g., EQRO or ombuds reports) conducted or contracted by the State,[3] if applicable ▪ Other data Rhode Island believes would benefit this evaluation, if applicable
Other sources	▪ Results of focus groups conducted by RTI subcontractor (Henne Group) ▪ Grievances and appeals ▪ Other sources of data, as available

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

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

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

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

References

Centers for Medicare & Medicaid Services (CMS): Medicare-Medicaid Capitated Financial Alignment Model Reporting Requirements. October 21, 2014. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/FinalCY2014CoreReportingRequirements.pdf. As obtained on October 27, 2015.

Walsh, E. G., Anderson, W., Greene, A. M., et al.: Measurement, Monitoring, and Evaluation of State Demonstrations to Integrate Care for Dual Eligible Individuals: Aggregate Evaluation Plan. Contract No. HHSM500201000021i TO #3. Waltham, MA. RTI International. December 16, 2013. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html. As obtained on January 6, 2016.

1. Introduction

1.1 Purpose

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

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

This report describes the State-specific evaluation plan for the Rhode Island demonstration. The evaluation activities may be revised if modifications are made either to the Rhode Island demonstration or to the activities described in the *Aggregate Evaluation Plan* (Walsh et al., 2013). Although this document will not be revised to address all changes that may occur, the annual and final evaluation reports will note areas where the evaluation as executed differs from this evaluation plan. This report provides an overview of the Rhode Island demonstration and provides detailed information on the framework for quantitative and qualitative data collection; the data sources, including data collected through RTI's State Data Reporting System (described in detail in the *Aggregate Evaluation Plan* [Walsh et al., 2013]); and impact and outcome analysis (i.e., the impact on beneficiary experience and quality, utilization, access to care, and costs) that will be tailored to Rhode Island.

1.2 Research Questions

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

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

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

- An overview of the Rhode Island demonstration
- Demonstration implementation, evaluation, and monitoring
- Impact and outcome evaluation and monitoring

Table 1
Research questions and data sources

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

— = not applicable.

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

2. Rhode Island Demonstration

2.1 Demonstration Goals

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

2.2 Summary of Demonstration

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

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

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

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

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

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

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

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

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

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

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

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

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

(continued)

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

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

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

(continued)

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

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

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

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

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

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

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

Aspect	Medicare fee-for-service data	Medicaid fee-for-service data	Encounter data[1]
Time frame of data	Baseline file = 2 years before the demonstration period (NCH Standard Analytic File). Evaluation file = all demonstration years (NCH TAP Files).	Baseline file = 2 years before the demonstration period. Evaluation file = all demonstration years.	Baseline file = Medicare Advantage plans submit encounter data to CMS as of January 1, 2012. RTI will determine to what extent these data can be used in the baseline file. Evaluation file = Medicare Advantage and MMP are required to submit encounter data to CMS for all demonstration years.
Potential concerns	—	Expect significant time delay for all Medicaid data.	CMS will provide the project team with data under new Medicare Advantage requirements. Any lags in data availability are unknown at this time.

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

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

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

RTI will compare the characteristics of beneficiaries who enroll with those of beneficiaries who are eligible but do not enroll and will conduct analyses to further explore demonstration effects on demonstration enrollees, acknowledging that selection bias must be taken into account in interpreting the results. Descriptive analyses for annual reports will present results on selected measures stratified by special populations (e.g., those using and not using behavioral health services, LTSS). Multivariate analyses performed for the final evaluation will account for differential effects for special populations in specification testing by using dummy variables for each of the specific special populations of interest one at a time so that the analyses can suggest whether quality, utilization, and cost are higher or lower for each of these groups.

4.4 Utilization and Access to Care

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

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

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

— = not available; FFS = fee-for-service; HCBS = home and community-based services; MCO = managed care organization; MMP = Medicare-Medicaid Plan; PAS = personal assistance services; RHO = Rhody Health Options.

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

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

The RTI evaluation team anticipates being able to develop traditional utilization measures for each of the service classes in ***Table 15*** (e.g., various inpatient use rates based on diagnoses of interest); however, as of this writing, the timing and availability of data that MMPs are required to submit have not been finalized. RTI will continue to work closely with CMS to understand how these data can best be used by the evaluation.

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

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

4.5 Quality of Care

Across all demonstrations RTI will evaluate a core quality measure set for monitoring and evaluation purposes. Quality measures have multiple data sources: claims and encounter data, which RTI will obtain from CMS and analyze for evaluation measures listed in ***Table 16***; and information collected by Rhode Island, CMS, or others and provided in aggregate to the RTI team for inclusion in reports. The latter may include Healthcare Effectiveness Data and Information Set (HEDIS) measures collected as part of health plan performance, other data Rhode Island requires its MMPs to report, and any beneficiary survey data collected by Rhode Island, CMS, or other entities (e.g., CAHPS). CMS and Rhode Island have also identified a set of quality measures that will determine the amount of quality withhold payments (i.e., RIte Care plans must meet quality standards to earn back a withheld portion of their capitated payments). The quality withhold measures, listed in the Rhode Island MOU, include some measures noted in this report, as well as additional measures. RTI expects to have access to the aggregated results of these additional measures and will include them in the evaluation as feasible and appropriate, understanding that these data are not available for the predemonstration period or for the comparison group.

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

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

Finally, the evaluation will analyze subgroups of interest, as appropriate, and look at measures that might be particularly relevant to them (e.g., measures that might be specific to people with developmental disabilities or behavioral health conditions). RTI will continue to work with CMS and the State to identify measures relevant to Rhode Island and will work to develop specifications for these measures.

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

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

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

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

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

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

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

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

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

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Cardiac rehabilitation Cardiac rehabilitation following hospitalization for AMI, angina CABG, PCI, CVA	Claims/encounter RTI will acquire and analyze	Care coordination	Yes	Percentage of demonstration-eligible beneficiaries evaluated in an outpatient setting who within the past 12 months have experienced AMI, CABG surgery, PCI, CVA, or cardiac transplantation, or who have CVA and have not already participated in an early outpatient CR program for the qualifying event/ diagnosis who were referred to a CR program.	Numerator: Number of demonstration-eligible Medicare-Medicaid enrollees in an outpatient practice who have had a qualifying event/diagnosis in the previous 12 months who have been referred to an outpatient cardiac rehabilitation/secondary prevention program. Denominator: Number of demonstration-eligible Medicare-Medicaid enrollees in an outpatient clinical practice who have had a qualifying cardiovascular event in the previous 12 months, who do not meet any of the exclusion criteria, and who have not participated in an outpatient cardiac rehabilitation program since the cardiovascular event.
Pressure ulcers Percent of high-risk residents with pressure ulcers (long stay)	MDS RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of all demonstration-eligible long-stay residents in a nursing facility with an annual, quarterly, significant change, or significant correction MDS assessment during the selected quarter (3-month period) who were identified as high risk and who have one or more Stage 2–4 pressure ulcer(s).	Numerators: Number of demonstration-eligible Medicare-Medicaid enrollees who are long-stay nursing facility residents who have been assessed with annual, quarterly, significant change, or significant correction MDS 3.0 assessments during the selected time window and who are defined as high risk with one or more Stage 2–4 pressure ulcer(s). Denominators: Number of demonstration-eligible Medicare-Medicaid enrollees who are long-stay residents who received an annual, quarterly, or significant change or significant correction assessment during the target quarter and who did not meet exclusion criteria.

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

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

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

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

(continued)

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

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

(continued)

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

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

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

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

NOTE: Definitions, use, and specifications are as of January 8, 2016.

4.6 Cost

To determine annual total costs (overall and by payer), the RTI evaluation team will aggregate the Medicare and Medicaid PMPM payments to the MMPs, FFS Medicaid payments for dental, HIV, and ID/DD residential services for MMP enrollees, and the costs for the eligible population that is not enrolled in the demonstration, per the intent-to-treat evaluation design. This approach will help us to detect overall cost impact and remove potential selection bias among beneficiaries who participate in the demonstration and those who opt out or disenroll. Any retrospective performance payments to the State will also be included in the final impact analysis.

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

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

4.7 Analytic Challenges

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

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