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

New York Fully Integrated Duals Advantage Program (FIDA)

Evaluation Design Plan

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New York FIDA Evaluation Design Plan

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Executive Summary

New York State (NYS) will implement a capitated model demonstration under the Financial Alignment Initiative. The initiative is known in New York as the Fully Integrated Duals Advantage (FIDA)[1] demonstration. Under the demonstration, the Centers for Medicare & Medicaid Services (CMS) and NYS will contract with Medicare-Medicaid Plans (MMPs, or FIDA Plans) to provide all Medicare and Medicaid services and certain additional long-term services and supports (LTSS) and health and wellness services. The FIDA demonstration will also implement an integrated Medicare-Medicaid appeals process under which external review of appeals for both Medicare and Medicaid services will be performed by the Integrated Administrative Hearing Office (IAHO) at the NYS Office of Temporary and Disability Assistance (OTDA).

The population eligible for the demonstration includes full-benefit Medicare-Medicaid enrollees, aged 21 and over, who require 120 days or more of community-based LTSS; who are eligible for the Nursing Home Transition and Diversion (NHTD) 1915(c) waiver; or who are eligible for facility-based LTSS.

The New York FIDA demonstration is being implemented in 8 of the State's 62 counties: Bronx, Kings, Nassau, New York (county), Queens, Richmond, Suffolk, and Westchester. Enrollment into the FIDA demonstration will be phased in gradually in Region 1 (Bronx, Kings, Nassau, New York, Queens, and Richmond) with the first phase of opt-in enrollment for community-based and facility-based LTSS populations beginning no sooner than January 1, 2015. Passive enrollment for the community-based, non-NHTD waiver population and new nursing facility residents will begin no sooner than April 1, 2015 (NYS Department of Health, n.d.; FIDA Demonstration Revised Enrollment Schedule, n.d.). Four more waves of enrollment will follow over the next 4 months; the final round of passive enrollment will begin August 1, 2015. In Region 2 (Suffolk and Westchester), opt-in enrollment will begin April 1, 2015, with passive enrollment beginning July 1, 2015. The FIDA demonstration will end no sooner than December 31, 2017, unless terminated prior to the planned end date, per the terms of the Memorandum of Understanding (MOU) between New York and CMS (CMS and NYS, 2013; hereafter, MOU, 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 New York FIDA demonstration as of January 7, 2015. The evaluation activities may be revised if modifications are made to either the New York FIDA 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.

[1] New York also plans to implement a Fully Integrated Duals Advantage Demonstration for Medicaid-Medicare enrollees served by the Office of People with Developmental Disabilities (OPWDD FIDA). A separate evaluation plan for OPWDD FIDA will be prepared at a later date.

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 and LTSS recipients). To achieve these goals, RTI will collect qualitative and quantitative data from New York each quarter; analyze Medicare and Medicaid enrollment and claims data; conduct site visits, beneficiary focus groups, and key informant interviews; and incorporate relevant findings from any beneficiary surveys conducted by other entities. Information from monitoring and evaluation activities will be reported in a 6-month initial implementation report to CMS and the State, quarterly monitoring reports provided to CMS and the State, annual reports, and a final evaluation report. The key research questions and data sources for each are summarized in ***Table ES-1***.

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 New York FIDA demonstration, and how do they differ from the State's previous system?	X	X	—	X
2) To what extent did New York implement the demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—	X
3) What impact does the New York FIDA 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 New York FIDA 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	X
5) What impact does the New York FIDA 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 New York FIDA demonstration have on health care quality overall and for beneficiary subgroups?	—	—	X	X
7) Does the New York FIDA 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

(continued)

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

Research questions	Stakeholder interviews and site visits	Beneficiary focus groups	Claims and encounter data analysis	Demonstration statistics[1]
8) What policies, procedures, or practices implemented by New York in its demonstration can inform adaptation or replication by other States?	X	X	—	X
9) What strategies used or challenges encountered by New York in its demonstration can inform adaptation or replication by other States?	X	X	—	X

—= not applicable; FIDA = Fully Integrated Duals Advantage.

[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 FIDA Plans.

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 plan-level monitoring (MOU, 2013). 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 New York FIDA 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 the 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 we will monitor for each design feature. Examples of tracking elements include efforts to build plan and provider core competencies for serving beneficiaries with various disability types, requirements for coordination and integration of clinical, LTSS, and behavioral health services; documentation of coordination activities between FIDA Plans 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 8*** in ***Section 4*** of this report aligns key elements identified in the CHCS framework with the demonstration design features listed in the demonstration implementation section. The goals of these analyses are to examine the beneficiary experience and how it varies by subpopulation and whether the demonstration has had the desired impact on beneficiary outcomes, including quality of life.

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, both to understand beneficiary experience with the new integrated appeals process as well as with the demonstration overall. 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 New York 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 may not seek services, 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 needs to be taken into account in interpreting the results.

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

Identifying the comparison group members will entail two steps: (1) selecting the geographic area from which the comparison group will be drawn and (2) identifying the individuals who will be included in the comparison group. The FIDA demonstration will be implemented in 8 of New York's 62 counties. Enrollment will be phased in starting January 1, 2015, with the last phase of passive enrollment beginning August 1, 2015 (NYS Department of

Health, n.d.; FIDA Demonstration Revised Enrollment Schedule, n.d.). Because New York does not intend to implement statewide, RTI will consider an in-State comparison group. We will use cluster analysis to identify potential in-State and out-of-State comparison Metropolitan Statistical Areas (MSAs) that are most similar to the demonstration areas in regard to environmental variables, including costs, care delivery arrangements, and State policy affecting Medicare-Medicaid enrollees.

Once comparison MSAs 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 treatment and comparison group members, using beneficiary-level data (demographics, socioeconomic, health, and disability status) and county-level data (health care market and local economic characteristics). We will remove from the comparison group any beneficiaries with a propensity score lower than the lowest score found in the demonstration group.

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

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

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

2. A descriptive analysis of quality, utilization, and cost measures with means and comparisons for subgroups of interest, including comparison group results, for annual reports. 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 the New York demonstration, individuals living in the community, those living in a facility, individuals under age 65, and individuals age 65 and older are subpopulations of interest for this evaluation. For these subpopulations and others, 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. 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, Medicaid, and New York FIDA 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 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). We will supplement these core measures with the following:

- Additional quality measures specific to New York 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 ***Section 4.1*** and ***Section 4.2***.

- HEDIS measures that FIDA 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 FIDA 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 paid to the FIDA 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 eliminate the effects of potential selection bias among beneficiaries who participate in the demonstration and those who opt out or disenroll. We will also 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 New York will be asked to provide and evaluation activities in which State staff will participate. As shown in this table, the RTI evaluation team will access claims, encounter, and other administrative data from CMS. These data, and how they will be used in the evaluation, are discussed in detail in this evaluation plan and in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

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

RTI will obtain data from:	Type of Data
CMS	● Encounter data (Medicare Advantage, Medicaid, and FIDA Plans) ● 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 States are 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; FIDA= Fully Integrated Duals Advantage; 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 May 1, 2014. 2014.

Centers for Medicare & Medicaid Services and The State of New York: Memorandum of Understanding (MOU) Between The Centers for Medicare & Medicaid Services (CMS) and The State of New York Regarding a Federal-State Partnership to Test a Capitated Financial Alignment Model for Medicare-Medicaid Enrollees, August 26, 2013. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/NYMOU.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 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, access to care, and cost. The evaluation includes an aggregate evaluation and State-specific evaluations.

This report describes the State-specific Evaluation Plan for the New York Fully Integrated Duals Advantage (FIDA) demonstration as of November 7, 2014. The evaluation activities may be revised if modifications are made to either the New York FIDA 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 New York FIDA 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, quality, utilization, access to care, and costs) that will be tailored to New York.

1.2 Research Questions

The major research questions of the New York FIDA 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 New York FIDA demonstration is based on the Memorandum of Understanding (MOU) between New York and CMS (CMS and New York State [NYS], 2013; hereafter, MOU, 2013); the special terms and conditions for New York's Section 1115(a) Partnership Plan and Federal-State Health Reform Partnership (F-SHRP) Demonstrations (CMS, 2012a; CMS, 2012b), approval letters (CMS, 2013); and discussions and e-mail communications with MMCO staff at CMS (CMS, 2014a, 2014b) and the NYS Department of Health as of October 31, 2014. The details of the evaluation design are covered in the three major sections that follow:

- An overview of the New York FIDA 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 New York FIDA demonstration, and how do they differ from the State's previous system?	X	X	—	X
2) To what extent did New York implement the demonstration as designed? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—	X
3) What impact does the New York FIDA 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 New York FIDA 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	X
5) What impact does the New York FIDA 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 New York FIDA demonstration have on health care quality overall and for beneficiary subgroups?	—	—	X	X
7) Does the New York FIDA 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 New York in its demonstration can inform adaptation or replication by other States?	X	X	—	X
9) What strategies used or challenges encountered by New York in its demonstration can inform adaptation or replication by other States?	X	X	—	X

— = not applicable; FIDA = Fully Integrated Duals Advantage.

[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 managed care organizations, called FIDA Plans.

2. New York FIDA Demonstration

2.1 Demonstration Goals

The goal of the New York Fully Integrated Duals Advantage (FIDA) demonstration is to improve enrollee (participant) experience in accessing care, deliver person-centered care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the State and Federal government through improvements in care and coordination. Key to the demonstration is the ability to meet participant needs, including the ability to self-direct, be involved in one's care, and live independently in the community. A strong component of the demonstration's ability to achieve these goals is the expectation that Medicare-Medicaid Plans (MMPs or FIDA Plans) and their contracted providers adhere to a philosophy of independent living and recovery, wellness principles, and cultural competence (MOU, 2013).

2.2 Summary of Demonstration

New York will implement a capitated model demonstration under the Financial Alignment Initiative for full-benefit Medicare-Medicaid enrollees, aged 21 and over; who require 120 days or more of community-based long-term services and supports (LTSS); who are eligible for the Nursing Home Transition and Diversion (NHTD) 1915(c) waiver; or who are eligible for facility-based LTSS (MOU, 2013, p. 6). CMS and the State of New York will establish a Federal-State Partnership to implement the demonstration that will include a three-way contract between CMS, the State, and participating plans. The demonstration will be implemented in 8 of New York's 62 counties: Bronx, Kings, Nassau, New York (county), Queens, Richmond, Suffolk, and Westchester (MOU, 2013).

Among those who are not eligible for enrollment in the FIDA demonstration are residents of a New York State (NYS) Office of Mental Health (OMH) facility; people who receive services through the Office of People with Developmental Disabilities (OPWDD); residents of psychiatric facilities; individuals receiving hospice care at the time of enrollment; residents of alcohol/substance use disorder long-term residential treatment programs; individuals on the Traumatic Brain Injury (TBI) waiver; and residents of assisted living programs. (For a complete list of populations that are not eligible for enrollment, see MOU, 2013, pp. 7–8.)

Enrollment in the FIDA demonstration will be phased in no sooner than January 1, 2015, and throughout 2015. Enrollment in the FIDA demonstration will be phased in gradually in Region 1 (Bronx, Kings, Nassau, New York, Queens, and Richmond) with the first phase of opt-in enrollment for community-based and facility-based LTSS populations beginning no sooner than January 1, 2015. The initial opt-in period will be followed by passive enrollment starting no sooner than April 1, 2015 (NYS Department of Health, n.d.; FIDA Demonstration Revised Enrollment Schedule, n.d.). Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE), those enrolled in a Medicare Advantage Special Needs Plan for institutionalized individuals, individuals eligible for the NHTD §1915(c) waiver, and individuals currently residing in a nursing facility are eligible to opt into the demonstration but are not eligible for passive enrollment (CMS and NYS, 2014). (For a complete list of those not eligible for passive

enrollment, see MOU, 2013, p. 8.) Unless specifically ineligible for passive enrollment (see previous paragraph), Medicare Advantage enrollees are eligible for passive enrollment. The FIDA demonstration will end no sooner than December 31, 2017, unless terminated prior to the planned end date, per the terms of the MOU (MOU, 2013).

To participate in the demonstration, FIDA Plans must meet all State requirements to become a Managed Long Term Care (MLTC) plan and have received a Certificate of Authority to operate an MLTC plan in the State by May 14, 2013; submit a Capitated Financial Alignment application to CMS and meet all other State and Medicare components of the FIDA Plan selection process; pass a joint CMS/State readiness review; and enter into a three-way contract with CMS and the State (MOU, 2013).

FIDA Plans will provide Medicare Parts A, B, and D services and Medicaid State Plan and 1115(a) and 1915(c) waiver items and services, including physical health, behavioral health, community-based LTSS, and long-stay nursing facility services (MOU, 2013). FIDA Plans also may provide supplemental services not currently covered by Medicare or Medicaid when identified by the interdisciplinary team as necessary to address participant needs as specified in the participant's Person-Centered Service Plan (MOU, 2013).

During the first year of implementation, FIDA Plans will be required to develop a plan for a fully integrated payment system through which providers would no longer be paid on a traditional fee-for-service basis but would instead be paid on an alternative basis (e.g., pay for performance, bundled payment). After State approval and no earlier than January 2016, FIDA Plans will be required to implement the approved plans, which will remain in effect throughout the demonstration (MOU, 2013; CMS, 2014c).

"Other than Medicare Part D appeals, which shall remain unchanged, the FIDA demonstration will implement an integrated Medicare-Medicaid appeals process. CMS and the State will work to continue to coordinate grievances and appeals for all services, including those related to Part D…" (MOU, 2013, p. 76). The integrated Medicare-Medicaid appeals process will consist of four levels: (1) Internal FIDA Plan-level review; (2) External review of appeals for both Medicare and Medicaid services by the Integrated Administrative Hearing Office (IAHO) at the New York State Office of Temporary and Disability Assistance (OTDA); (3) Medicare Appeals Council review; and (4) Federal District Court review. Continuation of benefits applies for appeals pending FIDA Plan, IAHO, and Medicare Appeals Council review based on parameters outlined in the MOU (MOU, 2013, pp. 76–79; NYS Department of Health, n.d. [NYSDOH Comments]).

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

Table 2
Key features of the New York FIDA 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 services; HCBS waiver services; nursing facility services	Medicaid State Plan services, HCBS-equivalent waiver services, nursing facility services, and supplemental benefits (at the plans' discretion and with State and CMS approval)
Payment method (capitated/FFS/ MFFS)		
Medicare	FFS and capitated	Capitated
Medicaid (capitated or FFS)		
Primary/medical	FFS and capitated	Capitated
Behavioral health	FFS	Capitated
LTSS (excluding HCBS waiver services)	Capitated (phased into mandatory MLTC plans by county)	Capitated
HCBS waiver services	FFS	Capitated
Other (specify)	N/A	N/A
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	Medical care coordination through Medicaid Advantage Plus plans, Medicare Advantage plans, or PACE, if applicable; Behavioral health—no care coordination; LTSS—care coordination by MLTC plans for those needing 120 days or more of LTSS; and Nursing facility residents: no care coordination unless enrolled in MLTC plan.	FIDA Plans are responsible for person-centered care coordination and care management through use of interdisciplinary teams.
Care coordination/case management for HCBS waivers and by whom	NHTD 1915(c) waiver participants: care coordination provided by Regional Resource Development Centers.	FIDA Plans are responsible for person-centered care coordination and care management through use of interdisciplinary care teams.

(continued)

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

Key features	Predemonstration	Demonstration[1]
TCM	N/A	N/A
Rehabilitation Option services	N/A	N/A
Clinical, integrated, or intensive care management	N/A	FIDA Plans are responsible for person-centered care coordination and care management through use of interdisciplinary care teams.
Enrollment/assignment		
Enrollment method	People age 21 and over needing 120 days or more of community-based LTSS are required to enroll in an MLTC plan.	Enrollees will have an opportunity to select a FIDA Plan. Those who do not select a FIDA Plan or opt out will be passively enrolled. Those who opt out of the FIDA demonstration will remain with their MLTC plan for Medicaid-covered community-based and facility-based LTSS, enroll in a Health and Recovery Plan for behavioral health services, and receive Medicare services through FFS or a Medicare Advantage Plan. Individuals may disenroll from their FIDA Plan at any time, effective on the first day of the following month.
Attribution/assignment method	N/A	N/A
Implementation		
Geographic area	N/A	Bronx, Kings, New York, Queens, Richmond, Nassau, Suffolk, and Westchester counties.

(continued)

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

Key features	Predemonstration	Demonstration[1]
Phase-in plan	N/A	Enrollment will be phased in. Community-based and facility-based populations can voluntarily enroll beginning no sooner than January 2015. Passive phased-in enrollment for both populations will begin no sooner than April 2015.
Implementation date	N/A	January 1, 2015.

FFS = fee for service; FIDA = Fully Integrated Duals Advantage; HCBS = home and community-based services; MFFS = managed fee for service; MLTC = Managed Long Term Care; NHTD = Nursing Home Transition and Diversion; N/A = not applicable; PACE = Program of All-inclusive Care for the Elderly; TCM = targeted case management.

[1] Information related to the demonstration in this table is from the Memorandum of Understanding between CMS and The State of New York (MOU, 2013) and the Three-Way Contract Template (CMS and NYS, 2014).

The characteristics of the population eligible to participate in the demonstration are presented in ***Table 3***. New York estimates that approximately 90,000 people will be eligible for the FIDA demonstration; approximately 22 percent of these individuals (20,000) reside in nursing facilities; the others live in the community and receive community-based LTSS (CMS, 2014c).

Table 3
Characteristics of eligible population for 2010

Characteristics	No. of beneficiaries	Percentage of eligible population
Developmental disabilities	—	—
Severe and persistent mental illness	—	—
Substance use	—	—
Chronic physical condition	—	—
Subpopulations (residing in facilities) [1]		
Eligible for facility-based LTSS	20,000	22%
Subpopulations (in community)[2]		
Require 120 days or more of community-based LTSS	70,000	78%
Eligible for NHTD §1915(c) waiver		
Total individuals potentially eligible for demonstration		
Medicare-Medicaid enrollees age 21 and over who require 120 days or more of community-based LTSS; are eligible for facility-based LTSS; or are eligible for NHTD §1915(c) waiver.	90,000	100%

— = not available; LTSS = long-term services and supports; NHTD = Nursing Home Transition and Diversion.

[1] Includes Medicare-Medicaid enrollees who require Medicaid-covered facility-based LTSS.

[2] Includes Medicare-Medicaid enrollees who require 120 or more days of community-based LTSS.

SOURCE: NYS Department of Health, 2014b; CMS, 2014c.

As shown in ***Table 4***, the total Medicare and Medicaid spending on Medicare-Medicaid enrollees making up the eligible population for this demonstration (i.e., those who would have been eligible to participate in the demonstration, had it been operational) was $7.4 billion in 2010. Information on the facility-based enrollees was not available for this evaluation plan.

Table 4
Total expenditures for Medicare-Medicaid enrollees eligible for the demonstration, 2010

Population	Medicaid expenditures	Medicare expenditures	Total expenditures
Eligible population			
Community-based LTSS group	$5.1 billion	$2.3 billion	$7.4 billion
Long-term care facility group	—	—	—

— = not available; LTSS = long-term services and supports.

NOTE: Table shows expenditures for Medicare-Medicaid enrollees who require 120 days or more of community-based or Medicaid-covered facility-based LTSS.

SOURCE: NYS Department of Health, 2012c.

2.3 Relevant Historical and Current Context

History/Experience with Managed Care. The New York FIDA demonstration builds on New York's long history of implementing and administering Medicaid managed care. Enrollment in managed care for Medicaid State Plan benefits grew from 650,000 beneficiaries in 1997 to more than 3.2 million as of July 2012. Early phases of mandatory enrollment in this "mainstream" managed care program included the Safety Net and Temporary Assistance to Needy Families (TANF) beneficiaries and beneficiaries receiving Supplemental Security Income (SSI), or who were otherwise disabled or over age 65. Medicare-Medicaid enrollees were not eligible for mandatory Medicaid managed care enrollment but could voluntarily enroll in a Medicaid Advantage Plus plan or Program of All-Inclusive Care for the Elderly (PACE) plan (CMS, 2012a). Between 2009 and 2012 New York expanded the groups of people eligible for mandatory enrollment (e.g., people with HIV/AIDS) and the number of counties with mandatory managed care (CMS, 2012a). As of November 2012, the expansion of the mainstream Medicaid managed care program was complete, with programs operating in all counties of the State (NYS Department of Health, 2013c).

Starting in 2012, New York began implementation of a mandatory managed long-term care (MLTC) program. This initiative was in response to recommendations emerging from New York's Medicaid Redesign Team (MRT), which had been established by Governor Andrew M. Cuomo in January 2011 to develop recommendations for reforming New York's health care system and reducing costs. Composed of stakeholders and experts in the health care industry, the MRT proposed major reforms to the delivery of health care services in New York. One of the recommendations, MRT #90, was to implement mandatory managed care for Medicare-Medicaid enrollees in need of LTSS; a second recommendation, MRT #101 (NYS Department of Health, 2011), was to develop initiatives to integrate and manage care for Medicare-Medicaid enrollees. In August 2012, CMS approved New York's request to implement mandatory managed care for people needing community-based LTSS (CMS, 2012b), including, for the first time, mandatory enrollment for Medicare-Medicaid enrollees.

In New York, all Medicaid enrollees who are aged 21 and over, and who require more than 120 days of community-based LTSS, are not otherwise ineligible or exempted, and reside in certain counties must be enrolled in New York's MLTC program. As currently authorized under its Section 1115(a) Partnership Plan and Federal-State Health Reform Partnership waivers, persons residing in nursing facilities and assisted living, or participating in the Traumatic Brain Injury Section 1915(c) waiver and the Nursing Home Transition and Diversion Section 1915(c) waiver are not eligible for mandatory enrollment. New York received authorization to phase in mandatory enrollment for participants in its Long-Term Home Health Care Program. Individuals aged 18 to 21, in need of community-based long-term care and needing a nursing-facility level of care may voluntarily enroll (CMS, 2012b).

Under the managed long-term care program, Medicare-Medicaid enrollees can choose among three MLTC plan models: the Program of All-Inclusive Care for the Elderly (PACE); Medicaid Advantage Plus plans; and partially capitated MLTC Medicaid plans (NYS Department of Health, 2012b, p. 5). PACE provides comprehensive primary, acute, and long-term care in a day center setting and in the home. Medicaid Advantage Plus plans, with

enrollment in a companion Medicare Advantage plan, include comprehensive acute, primary, and long-term care services. Eligibility for the Medicaid Advantage Plus and the PACE program is limited to those requiring a nursing-facility level of care. The third option, a partially capitated MLTC plan, provides long-term (personal care, home health) and ancillary (transportation, dental, rehabilitative therapies) health care services with an integrated care management component (NYS Department of Health, 2012b, p. 5).

Mandatory enrollment into MLTC plans for Medicaid services began in 2012 and continues in 2014. People eligible for the following services are required to enroll in MLTC plans: those needing personal care, adult day health, or home health over 120 days; and those in the consumer-directed personal care assistance program. Mandatory enrollment began in New York City with notification sent to targeted populations in July 2012; auto-assignment began in November 2012. Enrollment in New York City was phased in by service type, by borough, and by zip code. Mandatory enrollment in managed long-term care was phased in throughout other areas of the State in 2013. Counties included in enrollment were Nassau, Suffolk, and Westchester (January 2013); Rockland and Orange counties (June 2013); and Albany, Erie, Onondaga, and Monroe counties (December 2013) (NYS Department of Health, 2013a). Implementation is scheduled to be complete statewide by February 2015. (NYS Department of Health, n.d. [NYSDOH transition timeline]).

The New York FIDA demonstration will build on the implementation of mandatory enrollment of Medicaid enrollees in managed long-term care plans. Unless they opt out, the following individuals will be passively enrolled in a FIDA Plan: Medicare-Medicaid enrollees who are community-based LTSS program participants aged 21 or older who have opted in or have been mandatorily enrolled in Medicaid MLTC plans; and contingent on approval of an amendment to New York's Partnership Plan Section 1115(a) waiver, Medicare-Medicaid enrollees who are eligible for (but not currently receiving) facility-based LTSS (NYS Department of Health, n.d. [NYSDOH Comments]; CMS and NYS, 2014.

Other Initiatives. Several other initiatives are being implemented in the same areas covered by the FIDA demonstration.

The Bronx Health Access Network is one of 23 Pioneer Accountable Care Organizations (ACOs) nationwide, and is located within one of the eight counties served by the FIDA demonstration. Participants in the Bronx ACO will not be passively enrolled in the FIDA demonstration but will be able to opt in.

New York's Delivery System Reform Incentive Payment (DSRIP) program focuses on transforming New York's safety net system; improving accountability for reducing avoidable hospital use and improving other health and public health measures; and ensuring the sustainability of delivery system transformation through managed care payment reform. The DSRIP program is funded through savings in Federal financial participation to be achieved under New York's Partnership Plan §1115(a) demonstration program, as amended April 14, 2014 (CMS, 2014d).

New York is also participating in the national Balancing Incentive Program (BIP). This program provides States with additional Federal funding to implement structural changes to

facilitate rebalancing the percentage of individuals in need of LTSS in the home versus in institutional settings. This grant award began April 1, 2013, and will end September 30, 2015. Under this grant, New York is expanding and enhancing its New York Connects system to provide No Wrong Door access to long-term services and supports (NYS Department of Health, 2014c, although expansion has not yet occurred in all demonstration counties (NYS Department of Health, 2014a). States participating in BIP must establish standards for conflict-free eligibility assessments. As a condition of its §1115(a) Partnership waiver (CMS, 2014d), New York recently began implementation of conflict-free evaluation and enrollment services. Implementation will be phased in across regions and is expected to be complete in the demonstration area in February 2015 (NYS Department of Health, 2014b).

The Greater New York Hospital Association (GNYHA) Foundation is participating in CMS's initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents. In partnership with 30 nursing facilities located in New York City and Long Island, the GNYHA initiative places registered nurse care coordinators at the nursing facility to provide evidence-based interventions to reduce avoidable hospitalizations for long-stay residents. Nursing facility participation began in 2013 and will extend through 2016.

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3. Demonstration Implementation Evaluation

3.1 Purpose

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

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

3.2 Approach

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

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

3.3 Monitoring Implementation of the Demonstration by Key Demonstration Design Features

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

Table 5
Demonstration design features and key components

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

(continued)

Table 5 (continued)
Demonstration design features and key components

Design feature	Key components
Integrated delivery systems supports	• Care team composition • Health IT applied throughout the demonstration (at State level, by FIDA Plans, at provider level, or other) • Data (Medicare claims or encounter data) and other feedback to FIDA Plans, medical/health homes, other providers (by the State or other entities) • Primary care practice support (e.g., coaching, learning collaboratives, training)
Care coordination/case management (by 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, health homes, medical homes • Phased enrollment of eligible populations • Workforce development for worker supply and new functions
Beneficiary engagement and protections	• Policies to integrate Medicare and Medicaid grievances and appeals • Quality management systems • Ongoing methods for engaging beneficiary organizations in policy decisions and implementation • Approaches to capture beneficiary experience, such as surveys and focus groups

(continued)

Table 5 (continued)
Demonstration design features and key components

Design feature	Key components
Demonstration financing model and methods of payment to plans and providers	• Financing model: capitated • Innovative payment methods to FIDA Plans and/or to providers
Elements of payments to FIDA Plans and providers	• Incentives • Shared savings • Risk adjustment

FIDA = Fully Integrated Duals Advantage; IT = information technology; LTSS = long-term services and supports.

3.4 Implementation Tracking Elements

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

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

During site visit interviews and our ongoing communication with the State, we will collect detailed information on how New York has structured care coordination for beneficiaries enrolled in the demonstration. The evaluation will analyze the scope of care coordination responsibilities assigned to FIDA 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 FIDA 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 New York's entries. We will make additional calls to State agency staff and key informants as needed to keep abreast of demonstration developments. We will use site visit interviews to learn more about what factors are facilitating or impeding progress or leading to revisions in the New York FIDA demonstration implementation.

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

Table 6
Implementation tracking elements by demonstration design feature

Design feature	Tracking elements
Integrated delivery system	• Contracts with FIDA Plans • Documentation of coordination activities between FIDA 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 services by nontraditional workers • Innovative care delivery approaches adopted by the demonstration
Integrated delivery system supports	• Ongoing learning collaboratives of primary care providers • Support with dissemination and implementation of evidence-based practice guidelines (e.g., webinars for providers; topics addressed in learning collaboratives) • Decision-support tools provided or supported by State (e.g., practice-level or FIDA Plan-level reporting on QIs) • State efforts to build FIDA Plans and provider core competencies for serving beneficiaries with various types of disabilities • Provision of regular feedback to FIDA Plans and providers on the results of their performance measures
Care coordination	• Adoption of person-centered care coordination practices • State systems for collecting data on care coordination use • As available, care coordination activities directed to individual enrollees • 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

(continued)

Table 6 (continued)
Tracking elements by demonstration design feature

Design feature	Tracking elements
Benefits and services	• Phase-in of new or enhanced benefits, and methods to communicate them to enrollees and potential enrollees • Adoption of evidence-based practices and services for plans and providers (e.g., use of chronic disease self-management programs by practices, fall prevention programs, other)
Enrollment and access to care	• State efforts to provide integrated consumer information on enrollment, benefits, and choice of FIDA 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 • Adoption of new policies for beneficiary grievances and appeals based on demonstration experience • Role of the New York Ombuds program
Financing and payment	• Revisions to the demonstration's initial payment methodology, including risk-adjustment methodology • Risk-mitigation strategies • Performance incentive approaches • Value-based purchasing strategies

EHR = electronic health records; EMR = electronic medical records; FIDA = Fully Integrated Duals Advantage; LTSS = long-term services and supports; 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 New York's demonstration data. These progress indicators will be reported quarterly by New York through the SDRS, which will be the 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 New York FIDA 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 Financial Alignment Initiative as a whole. More detail on the SDRS can be found in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

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

Table 7
Examples of progress indicators

Indicator
Eligibility
No. of beneficiaries eligible to participate in the demonstration
Enrollment
Total no. of beneficiaries currently enrolled in the demonstration
No. of beneficiaries newly enrolled in the demonstration as of the end of the given month
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 FIDA Plans

FIDA = Fully Integrated Duals Advantage.

3.6 Data Sources

The evaluation team will use a variety of data sources to assess whether the New York FIDA 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 New York's approach to implementing its demonstration in order to develop a baseline profile of its current delivery system. Review of New York's agreements with CMS articulated through the demonstration Memoranda of Understanding (MOUs), waivers, contracts, and State Plan Amendments will further enhance our understanding of New York's approach.

- **Demonstration data (collected via the State Data Reporting System):** On a quarterly basis, we will collect data from New York to inform ongoing analysis and feedback to the State and CMS throughout the demonstration. Specifically, we will collect data to track policy and operational changes and progress indicators that are mostly numeric counts of key demonstration elements presented in ***Table 7***. These demonstration data also may include specific information provided by CMS or other entities engaged in this demonstration, and incorporated into the State Data Reporting System.
- **State agency staff, stakeholders, selected contractors, care coordination organizations, FIDA Plans/providers:** There will be at least two sets of site visits; the first one will occur within 6 months of demonstration implementation. Using two-person teams, supplemented with telephone interviews, we will obtain perspectives from key informants on progress to date, internal and external environmental changes, reasons New York took a particular course, and current successes and challenges. In addition to the site visits, and interim calls for clarification about State data submitted to the reporting system, in consultation with CMS we will develop a schedule of quarterly telephone interviews with various individuals involved in the demonstration.

  In addition to consumer advocates, as discussed in ***Section 4.1, Beneficiary Experience***, candidates for key informant interviews on demonstration implementation include, but are not limited to, the following:[2]

  – Representatives from demonstration advisory council
  – Representatives from CMS-State Contract Management Team
  – Representatives from CMS who are conducting case comparisons of Medicare appeals
  – State officials, such as the following:
    ◦ Department of Health Commissioner
    ◦ State Medicaid director
    ◦ Chief medical officer
    ◦ FIDA demonstration program manager
    ◦ LTSS program director
    ◦ Director, Division of Long Term Care
    ◦ Director, Financial Research and Analysis Unit
    ◦ FIDA Quality Manager
    ◦ FIDA Contract Coordinator(s)
    ◦ New York State Office of Temporary and Disability Assistance (OTDA)
  – Representatives from the State demonstration's advisory committee(s)

[2] We will also interview consumer advocates as discussed in ***Section 4.1, Beneficiary Experience***.

- FIDA Plan Representatives
- Representative of demonstration Ombuds Program (Independent Consumer Advocacy Network)

The site visit interview protocols used in the evaluation will contain a core set of questions that allow us to conduct an aggregate evaluation, questions specific to the financial alignment model (capitated or MFFS), as well as a few questions that are specific to the New York FIDA demonstration. Questions will be tailored to the key informants in New York, and the topic areas to be covered during key informant interviews will be developed once the demonstration is implemented; the topics for discussion 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 New York after the demonstration begins**.** A particular area of focus will be the New York FIDA demonstration's integrated appeals process, with a focus on early feedback in the 6-month report. 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 State and key informants we plan to interview.

3.7 Analytic Methods

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

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4. Impact and Outcomes

4.1 Beneficiary Experience

4.1.1 Overview and Purpose

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

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

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

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

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

State Data Reporting System. ***Section 3, Demonstration Implementation Evaluation***, describes topics we will monitor and document through interviews with New York FIDA 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 of how we will use these data to inform our understanding of the impact of the demonstration on its access to care and health outcomes.

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

- What impact does the New York FIDA 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 New York, CMS, or other entities. Qualitative data will be obtained directly from a beneficiary or beneficiary representative through focus groups and interviews. To avoid potential bias or conflict of interest, we will apply a narrow definition of "representative" to include only family members, advocates, or members of organizations or committees whose purpose is to represent the interest of beneficiaries and who are not service providers or do not serve in an oversight capacity for the initiative. Although no baseline qualitative data are available, beneficiaries will be asked about their experience before the demonstration and how it may have changed during the course of the demonstration.

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

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

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

Table 8
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	New York demonstration data[2]	Interviews with New York 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
Streamlined processes					
Beneficiaries can easily navigate the delivery system.	X	X	—	X	—

(continued)

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

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	New York demonstration data[2]	Interviews with New York agency staff on demonstration implementation
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	—
Health outcomes					
Beneficiary health rating	—	—	X	—	—

(continued)

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

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

(continued)

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

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

(continued)

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

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

(continued)

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

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	New York demonstration data[2]	Interviews with New York agency staff on demonstration implementation
Complaints, grievances, and appeals					
Beneficiaries have easy access to fair, timely, and responsive processes when problems occur.	X	X	—	X	—
Number and type of beneficiary complaints, grievance, and appeals.	—	—	—	X	—
Advocacy/member services					
Beneficiaries get assistance in exercising their rights and protections.	X	X	—	X	—
Finance and payment					
Provider incentives					
Beneficiary experience is taken into account when awarding provider and plan incentives.	X	—	—	—	X
Rate of 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 New York and 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 9 highlights some of the quantitative measures of beneficiary experience we will monitor and evaluate using demonstration statistics and claims or encounter data analysis. See ***Section 4.2*** for a discussion of the quality, utilization, and access to care measures we plan to examine as part of the overall evaluation of impact of the New York FIDA 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 New York 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 9
Demonstration statistics on quality, utilization, and access to care measures of beneficiary experience

Rate of auto-assignment to FIDA 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]

FIDA = Fully Integrated Duals Advantage.

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

4.1.3 Data Sources

We will rely on five major data sources to assess beneficiary experience as shown in ***Table 8***. In this section we describe our plan for using focus group and stakeholder interviews, results of beneficiary surveys planned by the State, CMS, or other entities; 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 New York to gain insight into how the initiative affects beneficiaries. To ensure that we capture the direct experience and observations of those served by the New York FIDA demonstration, focus groups will be limited to demonstration enrollees, their family members, and informal caregivers. ***Table 10*** shows our current plan for the composition and number of focus groups.

We are aware that New York has conducted its own focus group during the planning/design phase of the FIDA demonstration. We will use New York's findings to inform the content of the guides we use in conducting the 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 long-term services and supports (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 New York FIDA demonstration versus their perceptions of its effectiveness later in the New York FIDA 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 10
Purpose and scope of State focus groups

Primary purpose	To understand beneficiary experience with the demonstration and, where possible, to identify factors and design features contributing to their experience.
Composition	Each focus group includes 8–10 individuals who may be beneficiaries or family members or caregivers representing beneficiaries. These may include but are not limited to beneficiaries who • use community-based long-term services and supports • have multiple chronic conditions • are residents of nursing facilities • are under or over age 65
Number	Four focus groups

We will recruit focus group participants from eligibility and enrollment files independent of input from the State. In doing so, we will identify beneficiaries reflecting a range of eligibility, clinical, and demographic characteristics enrolled in the New York FIDA 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 in New York, we will consider convening focus groups with beneficiaries who have chosen to opt out or disenroll to understand their decisions. We will work closely with the New York FIDA 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 New York. We will investigate the prevalence of non-English–speaking beneficiaries in the eligible population, and determine whether to hold any of the focus groups in languages other than English. A preliminary focus group protocol is presented in the *Aggregate Evaluation Plan* (Walsh et al., 2013). The protocol may be modified based on final decisions about focus group composition, content, and our understanding of issues raised during implementation of the New York FIDA demonstration.

4.1.3.2 Key Stakeholder Interviews

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

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

A draft outline of the key stakeholder interviews 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 New York FIDA demonstration and the issues that arise during its planning/design phase and early implementation.

Table 11
Preliminary subpopulations 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 New York FIDA demonstration. These may include the following: ● Advocacy and consumer organizations representing the demonstration's target populations. ● Advocacy and consumer organizations participating in the Stakeholder Workgroup, Quality Workgroup, Appeals/Grievances Workgroup, and/or Outreach/Enrollment/Consumer Engagement Workgroup guiding the New York FIDA demonstration. ● Beneficiaries serving on the advisory committees and workgroups guiding the New York FIDA demonstration. ● Other advocates, including the Coalition to Protect the Rights of New York's Dually Eligible.
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 New York each year to be conducted with the same individuals each time, unless other stakeholders or topics of interest are identified. **Final year**: Up to eight telephone or in-person interviews.

FIDA = Fully Integrated Duals Advantage.

4.1.3.3 Beneficiary Surveys

The RTI evaluation team will not directly administer any beneficiary surveys as part of the evaluation, and we are not requiring that States administer beneficiary surveys for purposes of the evaluation. We will include relevant findings from beneficiary surveys already being conducted for this demonstration by New York, CMS, or other entities. All FIDA Plans will be required to conduct at least two Participant Feedback Sessions in their service area each year. New York will summarize the results and make them available to participants and the public (NYS Department of Health, 2012c, p. 25).

As part of CMS requirements for Medicare-Medicaid Plans, FIDA Plans will be required to conduct the Health Outcomes Survey (HOS) and CAHPS. The Medicare HOS and CAHPS surveys will be sampled at the FIDA 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 recommend common questions across demonstrations are shown in ***Table 8***.

4.1.3.4 Demonstration Data

We will use data about the demonstration that we collect from New York during site visits, from reports and other materials developed by the State, through the 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, New York plans to monitor quality using several plan performance and improvement measures (MOU, 2013, pp. 89–109). To the extent relevant, we will use findings from these State-specific metrics to augment our assessment of beneficiary experience and outcomes in New York.

4.1.3.5 Interviews with New York 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 New York demonstration staff. These interviews, described in ***Section 3***, will provide another

perspective on how New York 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 New York and compare and contrast those themes by subpopulation within and across States. Because it is implementing a capitated financial alignment model demonstration, we are particularly interested in comparing New York'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. In addition, we will request summaries of the required Participant Feedback Sessions conducted by the FIDA Plans. 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.

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 New York FIDA 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 New York FIDA demonstration have on utilization patterns in acute, long-term, and behavioral health services, overall and for beneficiary subgroups?

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

- Does the New York FIDA 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 New York FIDA 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 New York 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 New York FIDA demonstration. Results of descriptive analyses focusing on differences across years and important subgroups on key outcome variables will be included in the New York quarterly reports to CMS and the State and in the annual reports. Multivariate analyses will be included in the final evaluation. Savings will be calculated at least twice during the demonstration: once during the demonstration and once after the demonstration period has ended.

4.2.2 Approach

An appropriate research design for the evaluation must consider whether selection is a risk for bias.

Potential sources of selection bias exist in the New York FIDA 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 an Institutional Special Needs Plan (I-SNP), or Program of All Inclusive Care for the Elderly (PACE), will not be eligible for passive enrollment into the demonstration but can choose to disenroll from their current plans. 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 New York FIDA demonstration, regardless of whether they enroll in the demonstration or actively engage in the FIDA 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 FIDA 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 FIDA Plans to those who are eligible but do not enroll and 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 New York will include full-benefit Medicare-Medicaid enrollees who require 120 or more days of community-based LTSS, are eligible for the Nursing Home Transition and Diversion 1915(c) waiver, or who require Medicaid-covered facility-based LTSS. To analyze quality, utilization, and costs in the predemonstration period, and throughout the demonstration period, New York will submit a demonstration evaluation (finder) file that includes data elements needed for RTI to correctly identify Medicare-Medicaid enrollees for linking to Medicare and Medicaid data, and information about the enrollees eligible for or enrolled in the demonstration ***(Table 12)***. The file will list all of the Medicare-Medicaid beneficiaries eligible for the demonstration, with additional variables 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 personal identifying information for linking to Medicare and Medicaid data.

Table 12
State demonstration evaluation (finder) file data fields

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

(continued)

Table 12 (continued)
State demonstration evaluation (finder) file data fields

Data field	Length	Format	Valid value	Description
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 3 such data fields.

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 areas from which the comparison group will be drawn and (2) identifying the individuals who will be included in the comparison group.

Because New York does not intend to implement statewide, RTI will consider an in-State comparison group. If we are unable to identify in-State comparison areas that are similar to the demonstration areas or if the comparison population is not sufficiently large, we will consider using beneficiaries from both within New York and from Metropolitan Statistical Areas (MSAs) outside of New York that are similar to the demonstration areas. The approach for identifying out-of-State comparison MSAs would be the same as the process for identifying an in-State comparison group, described below.

We will use statistical distance analysis to identify potential comparison areas that are most similar to the New York FIDA demonstration counties in regard to costs, care delivery arrangements, and policy affecting Medicare-Medicaid enrollees, population density, and the supply of medical resources. The specific measures for the statistical distance analysis we will use include, but are not limited to, 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 patient care physicians per thousand population. The three LTSS variables capture how areas differ in the settings in which they provide these services. Variation in LTSS policy is most easily visible in the population using the most LTSS (i.e., those aged 65 and over). The relative importance of institutional care observed in that population is expected to affect such use in the population under age 65 as well.

Once comparison areas are selected, all Medicare-Medicaid enrollees in those areas who meet the demonstration's eligibility criteria will be selected for comparison group membership based on the intent-to-treat study design. The comparison areas will be determined within the first year of demonstration implementation, in order to use the timeliest data available. The comparison group members will be determined retrospectively at the end of each demonstration

year, allowing us to include information on individuals newly eligible or ineligible for the demonstration during that year. The comparison group will be refreshed annually to incorporate new entrants into the eligible population as new individuals become eligible for the demonstration over time. To ensure that the comparison group is similar to the demonstration group, we will compute propensity scores and weight comparison group beneficiaries using the framework described in ***Section 4.2.2.4*** of this report.

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 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 below.

3. **Accounting for enrollment in other demonstrations:** Some Medicare-Medicaid enrollees may not be suitable for comparison group selection because of participation in other demonstrations or enrollment in Accountable Care Organizations. We will work with CMS to specify these parameters and apply them to both New York and the comparison group.

4. **Medicaid data:** Significant delays currently exist in obtaining Medicaid data. If unaddressed, this problem could result in delays in formulating appropriate comparison groups. Timeliness of 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 13 provides an overview of the data sources to be used in the New York FIDA evaluation of quality, utilization, and cost. Data sources include Medicare and Medicaid fee-for-service data, Medicare Advantage encounter data, and FIDA 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 New York FIDA MOU require the State to provide timely Medicaid data through MSIS for the predemonstration and demonstration periods. Any delays in obtaining data may also delay portions of the evaluation.

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

Table 13
Data sources to be used in the New York FIDA 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 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, and Medicare-Medicaid 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 Medicaid 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) ● Medicaid eligibility files	Data will be collected from the following: ● CMS ● Medicare enrollment data

(continued)

Table 13 (continued)
Data sources to be used in the New York FIDA 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 FIDA Plans 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; FIDA = Fully Integrated Duals Advantage; MSIS = Medicaid Statistical Information System; NCH = National Claims History; TAP = monthly Medicare claims files.

[1] Encounter data from Medicare Advantage (MA) or PACE plans in the pre-period are needed to evaluate demonstration effects for beneficiaries who previously were enrolled in Medicare Advantage 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 New York FIDA demonstration evaluation will consist of the following:

1. a monitoring analysis to track quarterly changes in selected quality, utilization, access to care, and cost measures over the course of the New York FIDA demonstration (as data are available);

2. a descriptive analysis of quality, utilization, access to care, 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, access to care, and cost measures using an in-State or out-of State comparison group.

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

The approach to each of these analyses is outlined below in ***Table 14,*** and more detail is provided in the *Aggregate Evaluation Design Report* (Walsh et al., 2013). The starting date for the New York FIDA demonstration's baseline period and each demonstration year will be based on the State's implementation date and, therefore, may represent a "performance period," not necessarily a calendar year. The activities for the analyses may be revised if modifications are made to the demonstrations or if data sources are not available as anticipated. If modifications to this evaluation plan are required, they will be documented in the annual and final evaluation reports as appropriate.

4.3.1 Monitoring Analysis

Data from Medicare FFS and Medicare Advantage encounter data, FIDA Plan encounter data, MSIS files, or other data provided by New York 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 admissions, cost per member per month, and all-cause hospital readmission and mortality. We will present the current value for each quarter and the predemonstration period value for each outcome to look at trends over time.

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

pertaining to uptake of certain new, additional LTSS currently available only through 1915(c) waivers (HCBS) and for consumer direction of personal care services.

The evaluation team will ask New York State to provide the full diagnostic codes required (ICD-9, HCPCS, CPT) to develop measures for admissions related to ambulatory care-sensitive conditions (ACSCs) and avoidable emergency room use.

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

Aspect	Monitoring analysis	Descriptive analysis	Multivariate analyses
Purpose	Track quarterly changes in selected quality, utilization, access to care, and cost measures over the course of the demonstration.	Provide estimates of quality, utilization, access to care, and cost measures on an annual basis.	Measure changes in quality, utilization, access to care, 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 be calculated (at least) once prior to the final evaluation.

FIDA = Fully Integrated Duals Advantage.

4.3.2 Descriptive Analysis of Quality, Utilization, and Cost Measures

We will conduct a descriptive analysis of quality, utilization, and cost measures for the New York FIDA 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, access to care, and cost measures, as well as changes in these measures across years or subgroups of interest within each year. The results of these analyses will be presented in the annual evaluation reports. The sections below outline the measures that will be included.

To perform this analysis, we will develop separate (unlinked) encounter, Medicare, and Medicaid beneficiary-level analytic files annually to measure quality, utilization, and cost. Though the Medicare, Medicaid, and encounter data will not be linked, the unlinked beneficiary-level files will still allow for an understanding of trends in quality, utilization, and cost measures. The analytic files will include data from the predemonstration period and for each demonstration year. Because of the longer expected time lags in the availability of Medicaid data, Medicare fee-for-service data and FIDA 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 FIDA Plan encounter data for the demonstration period. Medicaid fee-for-service data will be incorporated into later reports as they 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 FIDA Plans. Data will be developed for predemonstration and comparison group beneficiaries for a 2-year predemonstration period and for each of the years of the demonstration. The starting date for New York will be based on the State's implementation date and, therefore, may represent a "performance period," not necessarily a calendar year. In addition to demonstration-level analyses, analyses will also be performed separately for those in facilities versus those residing in the community to determine whether their experiences differ. 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 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. Chi-square and t-tests will be used to test for significant differences in use across years and between subpopulations, such as community versus nursing facility populations.

4.3.3 Multivariate Analyses of Quality, Utilization, and Cost Measures

In the final year of the evaluation, we will use data collected for the eligible population in New York and data for the selected comparison group that will have been adjusted using propensity-score weighting methods to analyze the effect of the demonstration using a difference-in-differences method. This method uses both pre- and post-period estimates for both the demonstration and comparison groups to estimate effects. This method will be applied to these data for each quality, utilization, access to care, 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

For these subpopulations and others, 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. We will investigate the feasibility of tracking information by subpopulation after the demonstration and comparison groups are identified. Descriptive analyses for annual reports will present results on selected measures stratified by subpopulations (e.g., community vs. nursing facility population).

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, access to care, and cost are higher or lower for each of these groups.

4.4 Utilization and Access to Care

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

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

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

— = not available; FFS = fee for service; FIDA = Fully Integrated Duals Advantage; 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 15*** (e.g., various inpatient use rates based on diagnoses of interest if the full set of diagnostic codes are reported); however, as of this writing, the timing and availability of FIDA 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.

We will ask New York to provide the full set of diagnostic codes (e.g., ICD-9 [International Classification of Diseases], HCPCS [Healthcare Common Procedure Coding System], CPT [Current Procedural Terminology]), needed for the evaluation to perform analyses relying on such codes (e.g., admissions for ACSCs).

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 16***; and information collected by New York, CMS, or others and provided in aggregate to the RTI team for inclusion in reports. The latter may include HEDIS measures collected as part of health plan performance, other data that the FIDA Plans are required to report, and any beneficiary survey data collected by New York, CMS, or other entities (e.g., CAHPS). CMS and New York have identified a set of quality measures that will determine the amount of quality withhold payments (i.e., FIDA Plans must meet quality standards to earn back a withheld portion of their capitated payments). The quality withhold measures, listed in the New York FIDA MOU (MOU, 2013, pp. 49–52), 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, acknowledging 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 the New York FIDA demonstration. ***Table 16*** provides a working list of the quality measures to be included in the evaluation for the New York FIDA 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 New York FIDA demonstration. We will finalize State-specific quality measures within the first year of implementation.

Many of the measures in ***Table 16*** 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.

The unique features of the New York FIDA demonstration suggest areas of special focus in quality of care analyses. New York will provide additional LTSS currently available only through 1915(c) waivers (HCBS), new supplemental services not presently covered by the traditional Medicare or Medicaid programs, and an option for consumer direction of services. The evaluation will analyze selected core quality measures for the subgroups receiving these services. In addition, we will analyze selected core quality measures by opt-in versus passive enrollment.

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 s 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 serious 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 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.

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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.

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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
Antidepressant medication management	Medical records (HEDIS EOC030)	Care coordination	No	Percentage of members 18+ who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	Numerator: Two rates are reported. (1) Effective acute phase treatment—newly diagnosed and treated demonstration participants who remain on antidepressant medication for at least 84 days. (2) Effective continuation phase treatment—newly diagnosed and treated demonstration participants who remained on antidepressant medication for at least 180 days. Denominator: Newly diagnosed and treated demonstration participants over age 18.
Diabetes care Comprehensive diabetes care: selected components—HbA1c control, LDL-C control, retinal eye exam	Medical records (HEDIS EOC020)	Prevention/care coordination	No	Percentage of demonstration participants 18–75 years of age with diabetes (type 1 and type 2) who had each of the following: HbA1c control, LDL-C control, and retinal eye exam.	Numerator: Number of these who had HbA1c control or LDL-C control, or retinal eye exam in year. Denominator: Demonstration participants 18–75 with type 1 or type 2 diabetes.

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

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

ACE = angiotensin-converting-enzyme; ARB = Angiotensin II receptor blockers; ACSC = ambulatory care-sensitive conditions; AMI = acute myocardial infarction; 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 measure changes over time.

NOTE: Definitions, use, and specifications are as of 1/7/2015.

Our analyses will pay particular attention to the types of care with the most change. The New York FIDA demonstration will include long-term services and supports. Thus, measures for all-cause readmission rates, ACSC hospitalization rates, avoidable emergency room use, pressure ulcer, and depression screening and follow-up will be of particular interest for the population of participants residing in nursing facilities as well as those residing in the community. We will continue to work with CMS and the State to identify measures relevant to New York 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 Medicaid per member per month (PMPM) payments paid to the FIDA 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. RTI will include Part D PMPM and any PMPM reconciliation data provided by CMS in the final assessment of cost impact to ensure that all data are available.

The evaluation will analyze cost data for the service types shown in ***Table 14*** 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 Medicaid fee-for-service data for the predemonstration and demonstration periods and FIDA Plan encounter data for the demonstration period will be critical for the evaluation. RTI will receive Medicaid data from CMS, but it will be important for New York to submit Medicaid fee-for-service data to CMS 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 FIDA 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 topics into analyses as necessary.

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