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

Minnesota Evaluation Design Plan

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Minnesota Evaluation Design Plan

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Executive Summary

The Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience is a statewide initiative intended to further strengthen integration of existing Medicare Advantage Special Needs Plans (SNPs) and Medicaid managed care plans participating in the Minnesota Senior Health Options (MSHO) program by testing administrative changes to better align the Medicare and Medicaid operational components of the program. The Memorandum of Understanding (MOU) between the Centers for Medicare & Medicaid Services (CMS) and Minnesota (CMS and State of Minnesota, 2013; hereafter, MOU, 2013) includes initiatives designed to integrate CMS and State oversight of MSHO; to clarify and simplify enrollee information; to expand available arrangements for purchasing Health Care Home services (the State's term for medical homes); and make program administration more efficient for CMS, the State, and plans. The demonstration began on September 12, 2013, and will continue until December 31, 2016 (MOU, 2013, p. 1).

Minnesota has a well-established program of integrated managed care for Medicare-Medicaid enrollees aged 65 or older with the MSHO program, which will be the platform for implementing this demonstration. MSHO plans have separate contracts with CMS and the State for the Medicare and Medicaid components of the program. MSHO will continue to operate under Medicare Advantage SNP, Medicare Part D, and Medicaid managed care policies and procedures, except as modified by the MOU and demonstration activities. The demonstration will not fundamentally change benefit packages, choice of providers and plans for beneficiaries, or the way MSHO plans contract with either the State or CMS (MOU, 2013, p. 5). Medicaid beneficiaries aged 65 or older must enroll in a Medicaid managed care plan in Minnesota, but enrollment in MSHO, an integrated Medicare-Medicaid managed care plan, is a voluntary alternative for Medicare-Medicaid enrollees. As of July 2014, MSHO enrollment was 35,294, or about 70 percent of Minnesota's full-benefit Medicare-Medicaid enrollees aged 65 or older (Minnesota Department of Human Services, 2014).

CMS contracted with RTI International to monitor the implementation of all State demonstrations under the State Demonstrations to Integrate Care for Dual Eligible Individuals and 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 Minnesota demonstration as of November 12, 2014. The final implementation monitoring and evaluation activities will be revised as needed based on information in the CMS-Minnesota negotiated work plan (under development at the time of this report), or modifications to the activities described in the *Aggregate Evaluation Plan* (Walsh et al., 2013). Although this document will not be revised to address all changes that may occur, the annual and final evaluation reports will note areas where the evaluation as executed differs from this evaluation plan.

The goals of the evaluation of the Minnesota demonstration are different from demonstrations under the Financial Alignment Initiative because Minnesota is not introducing a new approach to care delivery or financing in the same way as other demonstrations. As the evaluation monitors and evaluates demonstration implementation over time, the principal focus will be on understanding the policies and procedures necessary to integrate administrative

functions between Medicare and Medicaid and to identify strategies that can be used by other States. As with demonstrations under the Financial Alignment Initiative, the evaluation will also monitor a range of outcomes for the demonstration population as a whole, which in Minnesota is the MSHO enrollees, for MSHO subpopulations (e.g., those using and not using behavioral health services and LTSS and those residing in nursing facilities and in the community), and compare outcomes for all full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota to similar enrollees in other states; however, the intent of this analysis is to place the quality, utilization, and cost of services received by MSHO enrollees in the context of other States rather than to test a hypothesis that the Minnesota financing and service delivery model will affect those outcomes because MSHO is an existing program rather than a new financing and service delivery model. Given the scope of the Minnesota demonstration, the expectation is that there will be few, if any, significant changes in beneficiary outcomes. These goals are reflected in the research questions presented in ***Table ES-1.***

To achieve these goals, RTI will collect qualitative and quantitative data from Minnesota each quarter; analyze Medicare and Medicaid enrollment and claims data; conduct site visits, focus groups with plans and providers, 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 data sources for each are summarized in ***Table ES-1***.

As noted, the principal focus of the evaluation will be on the implementation of the administrative alignment activities, as well as monitoring utilization, quality, and cost for demonstration enrollees. The evaluation will also explore whether plans have observed changes in beneficiary experience due to administrative simplification. CMS has engaged an operations support contractor to monitor fulfillment of the demonstration requirements outlined in the MOU. RTI will integrate that information into the evaluation as appropriate.

Demonstration Implementation. Evaluation of demonstration implementation will be based on case study methods. The evaluation team will monitor progress and revisions to the demonstration and will identify transferable lessons from the Minnesota demonstration through the following: document review, ongoing submissions by the State through RTI's State Data Reporting System (e.g., enrollment and disenrollment statistics currently collected by the state and qualitative updates on key aspects of implementation), quarterly key informant telephone interviews, and at least two sets of site visits. A particular focus will be on lessons learned that other States can apply in integrating care for Medicare-Medicaid enrollees through a joint Medicare SNP–Medicaid managed care platform. ***Table 5*** in ***Section 3*** of this report provides an initial list of activities RTI will monitor over the course of the Minnesota demonstration. As the demonstration proceeds, RTI may include additional activities conducted by CMS and the State.

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

Table ES-1
Research questions and data sources

Research questions	Stakeholder interviews, site visits and focus groups	Claims and encounter data analysis	Demonstration statistics[1]
1) What are the primary design features of the Minnesota demonstration, and how do they differ from the State's previous system?	X	—	X
2) To what extent did Minnesota implement the demonstration as planned? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—
3) How do the State, MSHO plans, and providers perceive the effect of the alignment activities conducted by the demonstration?	X	—	X
4) Were there changes for MSHO enrollees, providers, or plans during the demonstration?	X	X	X
5) What are the utilization patterns in acute, long-term, and behavioral health services for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Do these utilization patterns change over time?	X	X	X
6) What is the level of health care quality for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Does health care quality change over time?	—	X	X
7) What is the cost of health care for MSHO enrollees overall and for key MSHO subgroups? Do these health care costs change over time?	X	X	X
8) How do MSHO-eligible full-benefit Medicare-Medicaid enrollees age 65 or older enrolled in MSC+ compare to MSHO enrollees? Does this change over time?	X	X	X
9) How do health care utilization, quality, and costs for full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota compare to the levels for similar individuals in other States or State groups? Does this change over time?	—	X	X
10) What strategies used or challenges encountered by Minnesota can inform demonstration adaptation or replication by other States?	X	—	—

— = not applicable; MSHO = Minnesota Senior Health Options, MSC+ = Minnesota Senior Care Plus, the Medicaid managed care program for seniors who do not enroll in MSHO.

[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 MSHO plans.

Beneficiary Experience. The experiences of beneficiaries under the demonstration is an important focus of the evaluation. To understand beneficiary experience, RTI will monitor State-reported data quarterly and will discuss issues related to the beneficiary experience during quarterly telephone follow-up calls and site visits with the State and with stakeholders. The evaluation team will also obtain data on grievances and appeals from CMS and, as available, other sources. 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. The Minnesota demonstration combines new administrative flexibilities with changes that have been incorporated in MSHO over many years, continuing the high level of Medicare/Medicaid integration in the MSHO model. Given that the Minnesota demonstration continues to support those long-term integration efforts, the quantitative analysis will focus on tracking outcomes over time for MSHO enrollees, who are the eligible population for the Minnesota demonstration, as well as key subgroups of MSHO enrollees (e.g., those using and not using behavioral health services and LTSS and those residing in nursing facilities and in the community). We will also compare the MSHO enrollees to MSHO-eligible full-benefit Medicare-Medicaid enrollees aged 65 or older enrolled in MSC+ in Minnesota. Finally, to place the Minnesota experience in context, the evaluation will also examine outcomes of all full-benefit Medicare-Medicaid enrollees aged 65 or older,[1] in relation to a comparison group of similar individuals from other States. We will focus on the comparison of all full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota and the comparison group since it is not possible to identify the seniors in the comparison group who would choose to enroll in MSHO if it were available to them. The intent of this analysis is to place the Minnesota experience in the context of similar enrollees in other States rather than to test a hypothesis that the Minnesota financing and service delivery model will affect those outcomes because MSHO is an existing program rather than a new financing and service delivery model.

Identifying a Comparison Group. To support the quantitative analyses, Minnesota will submit demonstration evaluation (finder) files to RTI quarterly. RTI will use this information to identify the characteristics of eligible and enrolled beneficiaries and to link to Medicare and Medicaid data. ***Section 4.2.2.1*** of this report provides more detail on the contents of the demonstration evaluation (finder) files.

To identify geographic areas in other States that are similar to Minnesota, the RTI team will use statistical distance analysis, looking at costs, care delivery arrangements, policy affecting Medicare-Medicaid enrollees, population density, and the supply of medical resources. Although the comparison areas will be selected based on similarities to Minnesota, further criteria may be included, such as areas with (or without) integrated Medicare-Medicaid programs. Final criteria will be developed in discussions with CMS. 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.

In comparing full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota with a comparison group, the evaluation team will have two areas of focus: the first will simply compare the observed levels of quality, utilization, and costs for full-benefit Medicare-Medicaid enrollees aged 65 or older in other areas with the levels observed for full-benefit Medicare-Medicare enrollees aged 65 or older in Minnesota; the second will seek to control for differences in the characteristics of the full-benefit Medicare-Medicaid enrollee populations in Minnesota and the comparison groups to provide a descriptive assessment of differences in the levels of quality, utilization, and costs that would be expected for senior full-benefit Minnesota Medicare-Medicaid enrollees *if* they lived in those other areas. To ensure that the comparison group for the

[1] Minnesota Senior Health Options (MSHO) is also limited to seniors in counties in which there is at least one plan offering MSHO. Currently, all counties in the State have at least one MSHO plan.

latter comparison is similar to the senior Medicare-Medicaid enrollees in Minnesota, the evaluation team will compute propensity scores and weight comparison group beneficiaries using the framework described in ***Section 4.2.2.4*** of this report.

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

1. a monitoring analysis to track changes in selected quality, utilization, and cost measures over the course of the demonstration for MSHO enrollees and subgroups of MSHO enrollees (as data are available);

2. a descriptive analysis of quality, utilization, and cost measures for MSHO enrollees for annual reports, with means and comparisons for MSHO subgroups of interest and for MSHO-eligible full-benefit Medicare-Medicaid enrollees aged 65 or older in MSC+ in Minnesota;

3. a descriptive analysis of quality, utilization, and cost measures for all full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota for annual reports, with means and comparisons for out-of-State comparison groups of full-benefit Medicare-Medicaid enrollees aged 65 or older; and

4. multivariate analyses of quality, utilization, and cost measures for full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota as compared to an out-of-State comparison group.

Subpopulation Analyses. For MSHO subpopulations of focus in the Minnesota demonstration (e.g., MSHO enrollees using and not using behavioral health services and LTSS and those residing in nursing facilities and in the community), RTI will evaluate trends in quality, utilization, and access to care for medical, LTSS, and behavioral health services; the evaluation team will also examine qualitative data gathered through interviews and surveys. Descriptive analyses for annual reports will present results on selected measures stratified by subpopulations (e.g., those using and not using behavioral health services and LTSS and those residing in nursing facilities and in the community).

Utilization and Access to Care. Medicare, Medicaid, and MSHO plan encounter data will be used to understand the levels and types of services used, ranging along a continuum from institutional care to care provided at home (see ***Table 11*** of this report for more detail).

Quality. Across all demonstrations, RTI will evaluate a core quality measure set for monitoring and evaluation purposes that is available through claims and encounter data. Although the Minnesota demonstration is focused on administrative simplification, the core quality measure set will still be monitored to document any changes in outcomes over the demonstration period. RTI will obtain these data from CMS (see ***Table 12*** of this report) and will supplement these core measures with the following:

- Additional quality measures specific to Minnesota 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.

- Healthcare Effectiveness Data and Information Set (HEDIS) measures that MSHO plans are required to submit.

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

Cost. To determine annual total costs (overall and by payer) for the MSHO enrollees and for all full-benefit Medicare-Medicaid enrollees aged 65 or older, RTI will aggregate the Medicare and Medicaid per member per month (PMPM) payments to the MSHO plans and any fee-for-service Medicare and Medicaid payments for Medicare-Medicaid enrollees in Minnesota. The evaluation team will include Part D PMPM and any PMPM reconciliation data provided by CMS in the final assessment of costs to ensure that all data are available. Demonstration costs will be calculated twice for the Minnesota demonstration using a regression-based approach. The methodology for determining changes in costs, if any, for the demonstration 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 that the RTI evaluation team will use to monitor demonstration progress and evaluate the outcomes of the State Demonstrations to Integrate Care for Dual Eligible Individuals and the demonstrations under the Financial Alignment Initiative. The table provides an overview of the data that Minnesota will be asked to provide and evaluation activities in which State staff will participate. As shown in this table, the evaluation team will access claims, encounter, and other administrative data from CMS. These data, and how they will be used in the evaluation, are discussed in detail in this evaluation plan and in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

Table ES-2
Sources of information for the evaluation of the Minnesota demonstration

RTI will obtain data from:	Type of data
CMS	• Encounter data (Medicare Advantage and Medicaid) • 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 • MSHO quality measures that Minnesota is required to report to CMS (listed in MOU) • MSHO reporting measures that health plans are required to report to CMS • 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 (can be submitted quarterly)[1] • Quarterly submissions of demonstration updates, including monthly statistics on enrollments and disenrollments • Participation in key informant interviews and site visits conducted by RTI team • Results from surveys, focus groups, or other evaluation activities (e.g., EQRO or Ombuds reports) conducted or contracted by the State,[2] if applicable • Other data State believes would benefit this evaluation, if applicable
Other sources	• Results of focus groups conducted by RTI subcontractor (Henne Group) • Grievances and appeals • Other sources of data, as available

CAHPS = Consumer Assessment of Healthcare Providers and Systems; EQRO = External Quality Review Organization; HCC = hierarchical condition category; HEDIS = Healthcare Effectiveness Data and Information Set; HOS = Health Outcomes Survey; MDS = Minimum Data Set; MOU = Memorandum of Understanding; MSHO = Minnesota Senior Health Options; RXHCC = prescription drug hierarchical condition category.

[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) and the State of Minnesota: Memorandum of Understanding (MOU) Regarding a Federal-State Partnership to Align Administrative Functions for Improvements in Medicare-Medicaid Beneficiary Experience. September 12, 2013. http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MNMOU.pdf.

Minnesota Department of Human Services: Minnesota Health Care Programs Managed Care Enrollment Totals, July 2014. http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_185169. As obtained on August 4, 2014.

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1. Introduction

1.1 Purpose

The Medicare-Medicaid Coordination Office (MMCO) and Innovation Center at CMS have created the State Demonstrations to Integrate Care for Dual Eligible Individuals and the Financial Alignment Initiative for States to test integrated care models for Medicare-Medicaid enrollees. CMS contracted with RTI International to monitor the implementation of the demonstrations and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and State-specific evaluations.

This report describes the State-specific Evaluation Plan for the Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience as of November 12, 2014. Key information about the details of the Minnesota demonstration will be included in the CMS-State negotiated work plan that will specify the activities to be undertaken during this demonstration and their proposed timeline. That work plan is under development at the time of this report; therefore, this evaluation plan is based on the evaluation team's current understanding of proposed demonstration activities. The evaluation activities may be revised based on information gleaned during the initial site visit, the CMS-State work plan, or if modifications are made to either the Minnesota 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 Minnesota demonstration and provides detailed information on the framework for quantitative and qualitative data collection; the data sources, including data collected through RTI's State Data Reporting System (SDRS; described in detail in the *Aggregate Evaluation Plan* [Walsh et al., 2013]);[2] and outcome analysis (i.e., the changes in beneficiary experience, quality, utilization, access to care, and costs) that will be tailored to Minnesota.

The goals of the evaluation of the Minnesota demonstration are different from demonstrations under the Financial Alignment Initiative because Minnesota is not introducing a new approach to care delivery or financing. As the evaluation monitors and evaluates demonstration implementation over time, the principal focus will be on understanding the policies and procedures necessary to integrate administrative functions between Medicare and Medicaid and to identify strategies that can be used by other States. As with demonstrations under the Financial Alignment Initiative, the evaluation will also monitor a range of outcomes for the MSHO population as a whole, for subpopulations (e.g., MSHO enrollees using and not using behavioral health services and LTSS and those residing in nursing facilities and in the community), and for all full-benefit Medicare-Medicaid enrollees aged 65 or older; however, the intent is to monitor the quality, cost, and utilization of services received by demonstration enrollees rather than to test a hypothesis that the Minnesota financing and service delivery model

[2] Because the Minnesota demonstration is based on the existing MSHO program (i.e., the State is not implementing a managed care model integrating Medicare and Medicaid for the first time), not all aspects of the SDRS data collection described in the *Aggregate Evaluation Plan* will apply.

will affect those results because MSHO is an existing program rather than a new financing and service delivery model.

Given the scope of the Minnesota demonstration, the expectation is that there will be few, if any, significant changes in beneficiary outcomes. These goals are reflected in the research questions presented in ***Table 1***.

1.2 Research Questions

Preliminary research questions for the Minnesota evaluation are presented in ***Table 1*** with an identification of possible data sources. These questions are focused on understanding the policies and procedures necessary to integrate administrative functions between Medicare and Medicaid and to identify strategies that can be used by other States. Revisions and additions may be made once further details about the demonstration's activities become available, through a review of the work plan and information obtained during the initial site visit. The evaluation will use multiple approaches and data sources to address these questions. These sources are described in more detail in ***Sections 3*** and ***4*** of this report.

Unless otherwise referenced, the preliminary summary of the Minnesota demonstration is based on the Memorandum of Understanding (MOU) between the State and CMS (CMS and State of Minnesota, 2013; hereafter, MOU, 2013); a Minnesota Department of Human Services (DHS) presentation to stakeholders on the demonstration (Parker, 2013); Minnesota DHS managed care enrollment reports (Minnesota DHS, 2014); the public notice and Minnesota's comments on the CMS Alignment Initiative (Federal Register, 2011; Godfrey, 2011); and communications with MMCO and the Center for Medicare and Medicaid Innovation staff at CMS regarding the demonstration as of October 31, 2014. The details of the evaluation design are covered in the three major sections that follow:

- An overview of the Minnesota demonstration
- Demonstration implementation, evaluation, and monitoring
- Outcome evaluation and monitoring

Table 1
Research questions and data sources

Research questions	Stakeholder interviews, site visits and focus groups	Claims and encounter data analysis	Demonstration statistics[1]
1) What are the primary design features of the Minnesota demonstration, and how do they differ from the State's previous system?	X	—	X
2) To what extent did Minnesota implement the demonstration as planned? What factors contributed to successful implementation? What were the barriers to implementation?	X	—	—
3) How do the State, MSHO plans, and providers perceive the effect of the alignment activities conducted by the demonstration?	X	—	X
4) Were there changes for MSHO enrollees, providers, or plans during the demonstration?	X	X	X
5) What are the utilization patterns in acute, long-term, and behavioral health services for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Do these utilization patterns change over time?	X	X	X
6) What is the level of health care quality for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Does health care quality change over time?	—	X	X
7) What is the cost of health care for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Do these health care costs change over time?	X	X	X
8) How do MSHO-eligible full-benefit Medicare-Medicaid enrollees age 65 or older enrolled in MSC+ compare to MSHO enrollees? Does this change over time?	X	X	X
9) How do health care utilization, quality, and costs for full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota compare to the levels in other States or State groups? Does this change over time?	—	X	X
10) What strategies used or challenges encountered by Minnesota can inform demonstration adaptation or replication by other States?	X	—	—

— = not applicable; MSHO = Minnesota Senior Health Options, MSC+ = Minnesota Senior Care Plus, the Medicaid managed care program for seniors who do not enroll in MSHO.

[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 MSHO plans.

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2. Minnesota Demonstration

2.1 Demonstration Goals

The Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience is a statewide initiative intended to further strengthen integration of existing Medicare Advantage Special Needs Plans (SNPs) and Medicaid managed care plans participating in the MSHO program by testing administrative changes to better align the program's Medicare and Medicaid operational components. Its results are also expected to provide lessons that can be applied to further advance integration of similar programs in other States. The State and CMS will work together to do the following:

- Integrate CMS and State oversight of MSHO plans.
- Clarify and simplify enrollee information and processes.
- Expand purchasing arrangements with Integrated Care System Partnerships (ICSPs), which may be used to integrate Health Care Home (the State's term for medical homes) services.
- Make program administration more efficient for CMS, the State, and plans.

In addition, the demonstration Memorandum of Understanding (MOU) between CMS and the State formalizes certain existing, pre-demonstration agreements between CMS and the State that align some Medicare SNP and Medicaid managed care policies and procedures in administration of the MSHO program. The MOU also authorizes certain new exceptions to Medicare processes and timelines to improve alignment of Medicare and Medicaid requirements. These preexisting agreements will be referenced in evaluation reports on the Minnesota demonstration to provide other States a complete documentation of the policies adopted to better integrate Medicare SNP and Medicaid managed care programs for beneficiaries.

2.2 Summary of Demonstration

The Minnesota demonstration is intended to further strengthen integration of existing Medicare Advantage SNPs and Medicaid managed care plans by testing administrative changes to better align the two programs. Minnesota has a well-established program of integrated managed care for Medicare-Medicaid enrollees, the MSHO program, which is the platform for implementation of this demonstration. The demonstration began on September 12, 2013, and will continue until December 31, 2016 (MOU, 2013).

Minnesota was one of 15 States that received demonstration design contracts in 2011 to develop an approach to integrate care for Medicare-Medicaid enrollees. CMS and the State have agreed upon a demonstration design focused on improving administrative alignment of Medicare SNP and Medicaid managed care procedures through the existing MSHO program. ***Section 2.3***, ***Relevant Historical and Current Context***, includes a basic overview of the MSHO program.

The Minnesota demonstration's proposed activities correspond to many of the issues being addressed by the CMS Alignment Initiative, designed to "identify and address conflicting requirements between Medicare and Medicaid that potentially create barriers to high quality, seamless and cost-effective care for dual eligible beneficiaries" (Federal Register, 2011, p. 28197).

As noted, the Minnesota demonstration will be implemented through the existing MSHO program. Because the MSHO integrated program structure is already established, there will be no significant changes in the way beneficiaries receive services: benefits will remain the same; services will be financed through existing Medicare SNP and Medicaid managed care contracts, and provider networks will remain intact.

Under the demonstration, MSHO plans will continue to operate under two separate contracts, contracting with the State as Medicaid managed care organizations, and contracting with CMS as SNPs. MSHO plans will continue to comply with Medicare Advantage and SNP requirements and must also comply with Medicaid managed care requirements incorporated in the MSHO contract.

2.2.1 Demonstration Alignment Activities

Under the demonstration, CMS and the State will collaborate to improve alignment in several areas, such as enrollment, contract oversight and monitoring, appeals and grievances, reporting requirements, beneficiary notices, and quality metrics. Below is a preliminary list of domains expected to be addressed by the demonstration, with illustrative examples of the types of activities to be undertaken.

2.2.1.1 Enrollment

The State will test new, simplified language on enrollment forms and beneficiary notices (MOU, 2013, pp. 5, 19–20).

2.2.1.2 Network Adequacy

CMS will conduct a new network review of MSHO plans, using existing Medicare Advantage methodology to test new standards designed to more accurately reflect the Medicare-Medicaid population. The State will have an opportunity to review the network submissions and provide input to CMS on local delivery systems considerations (MOU, 2013, pp. 6, 20–21).

2.2.1.3 Beneficiary Protections from Cost Sharing

Through the SNP bidding process, CMS and the State will work with MSHO plans to minimize the Medicare Advantage and Part D premiums and copayments paid by enrollees (MOU, 2013, pp. 6, 17–18, 21–22).

2.2.1.4 Integrated Appeals and Grievances

A simplified and integrated model beneficiary notice for appeals explanations will be developed for CMS approval. The 60-day time frame available to beneficiaries for filing appeals

for Medicare benefits will be extended to 90 days to align with the Medicaid timeline (MOU, 2013, p. 7).

2.2.1.5 Contract Management

CMS and the State will designate representatives for a CMS-State Contract Management Team. Procedures will be established by CMS and the State for day-to-day MSHO plan monitoring (MOU, 2013, p. 24).

2.2.1.6 Quality Measurement

The State will test adjustments and additions to the existing quality measures required in MSHO plans' Medicare and Medicaid contracts. For example, the State and CMS will work with MSHO plans on developing and testing of State-specific measures that could be incorporated into a modified star rating system for MSHO plans and integrated plans in other States. The State and CMS will also collaborate to streamline the number of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys conducted to reduce burdens on MSHO plans and beneficiaries. CMS and the State will make the Health Outcomes Survey (HOS) available in additional languages, as appropriate and subject to funding availability (MOU, 2013, p. 26).

CMS and the State will also test approaches to develop appropriate metrics for integrated care, for adapting provider-level measures for use at the plan level, and measuring community integration. The State will work with a national consensus-building organization (depending on external funding) to develop new or revise existing outcome measures (MOU, 2013, pp. 26–27).

2.2.1.7 Performance Improvement

The State will work with CMS and MSHO plans to streamline and reduce duplicate reporting requirements for quality improvement activities, including external quality reviews conducted by the Quality Improvement Organization under the Medicare Advantage Contracts and External Quality Review Organization under the Medicaid managed care contracts. The State will have input into topics for Medicare Advantage SNP projects on Quality Improvement Programs, Performance Improvement Programs, and Chronic Care Improvement Programs. MSHO plans will be able to use a Medicare format for Medicaid Performance Improvement Programs, rather than develop separate approaches for each quality program (MOU, 2013, pp. 9, 25–27).

2.2.1.8 Provider Purchasing Agreements

The State will make available to MSHO plans new alternative purchasing arrangements through the Integrated Care System Partnerships which may be used to integrate Health Care Home services (MOU, 2013, pp. 5–6).

2.2.1.9 SNP Model of Care

For the first time, the State will have an opportunity to provide input into SNP Model of Care elements for MSHO plans to improve alignment with MSHO requirements and processes for care coordination, assessments, and related functions (MOU, 2013, p. 22).

2.2.1.10 Marketing, Outreach, and Education Activity

The State and CMS will work with MSHO plans to revise existing integrated beneficiary communication materials to simplify their presentation and to improve incorporation of Medicaid-related information into required SNP materials, including a summary of benefits, an annual notice of change, combined provider and pharmacy directory, integrated enrollment form, and a member handbook (MOU, 2013, pp. 22–23).

This preliminary list of demonstration alignment activities will be revised when the demonstration work plan is finalized.

Table 2 provides a summary of the key characteristics of the MSHO program, which is the platform through which the demonstration's alignment activities will be implemented. The table illustrates that the Minnesota demonstration makes no changes to MSHO program benefits, payment method, care coordination, or program enrollment method.

Table 2
Key features of MSHO predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Summary of covered benefits		
Medicare	—	No change in benefits
Medicaid	—	No change in benefits
Payment method (capitated/FFS/MFFS)		
Medicare	Capitated (Medicare MSHO SNP)	Unchanged
Medicaid (capitated or FFS)		
Primary/medical	Capitated (Managed care contracts)	Unchanged
Behavioral health	Capitated (Managed care contracts)	Unchanged
LTSS (excluding HCBS waiver services)	Capitated (Managed care contracts)	Unchanged
HCBS waiver services	Capitated (Managed care contracts)	Unchanged
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	Enrolled beneficiaries receive all Medicare and Medicaid services from one plan with one membership card and have one care coordinator.	Unchanged

(continued)

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

Key features	Predemonstration	Demonstration[1]
Enrollment/assignment		
Enrollment method, if applicable	Enrollment in Medicaid managed care is mandatory in Minnesota for Medicaid beneficiaries aged 65 or older, unless they meet an exclusion, such as having a spend down, or if they are in a voluntary managed care program such as Special Needs BasicCare. There is a voluntary exclusion for those who qualify as having a serious and persistent mental illness (SPMI) as defined in state law; few take this exclusion. For full-benefit Medicare-Medicaid beneficiaries aged 65 or older, enrollment in MSHO is a voluntary, integrated alternative to mandatory enrollment in a Medicaid-only plan.	Unchanged
Implementation		
Geographic area	Statewide	Statewide
Implementation date	N/A	September 12, 2013

FFS = fee for service; HCBS = home and community-based services; LTSS = long-term services and supports; MFFS = managed fee for service; MSHO = Minnesota Senior Health Options; N/A = not applicable; SNP = Special Needs Plan.

[1] Information related to the demonstration in this table is from the Memorandum of Understanding (MOU, 2013).

The characteristics of enrollees in the MSHO program are presented in ***Table 3***. Three-quarters (74 percent) of MSHO enrollees required an institutional level of care in State fiscal year 2011: 30 percent resided in nursing facilities, and 44 percent resided in the community using home and community-based services (HCBS) waiver services, primarily through the Elderly Waiver. The remaining 26 percent lived in the community and did not receive waiver services but may have received personal care assistance (Minnesota Department of Human Services [DHS], 2012, pp. 4, 6).

Table 3
Characteristics of Medicare-Medicaid enrollees in MSHO for SFY 2011

Characteristics	No. of beneficiaries	Percentage of eligible population
Subpopulations residing in nursing facilities[1]	11,277	30%
Subpopulations (in community)		
With Elderly Waiver services	15,348	42%
With other waiver services	733	2%
With no waiver services	9,559	26%
Total Medicare-Medicaid enrollees in MSHO	36,917	100%

MSHO = Minnesota Senior Health Options.

[1] Nursing facilities providing Medicaid nursing facility services.

SOURCE: Minnesota Department of Human Services: Redesigning Integrated Medicare and Medicaid Financing and Service Delivery for People with Dual Eligibility in Minnesota. April 26, 2012. Table 2, p. 6.

As shown in ***Table 4***, the total Medicare and Medicaid spending on all full and partial Medicare-Medicaid enrollees residing in Minnesota in calendar year 2007 was $4.9 billion.

Table 4
Total expenditures for full and partial Medicare-Medicaid enrollees statewide, CY 2007

Population	Medicaid expenditures	Medicare expenditures	Total expenditures
Eligible population	$2.3 billion	$2.6 billion	$4.9 billion

SOURCE: Centers for Medicare & Medicaid Services: Medicare-Medicaid State Profile: Minnesota. n.d.

2.3 Relevant Historical and Current Context

Minnesota has a long history of capitating Medicaid benefits, including services for older adults, dating back to the mid-1980s (Parker, 2013). The State began integrating care for Medicare-Medicaid enrollees through managed care with the launch of the MSHO program in 1997 under the authority of a Medicaid 1115(a) demonstration and a Medicare 222 waiver. In 2005, the demonstration ended and all MSHO plans became Medicare SNPs. At the same time, with the implementation of Medicare Part D, CMS allowed SNPs to passively enroll Medicare-Medicaid enrollees who had been enrolled in a Medicaid managed care plan offered by the same managed care organization. This one-time passive enrollment boosted MSHO enrollment from 9,800 to 33,400.

MSHO continues to operate statewide, and as of July 2014, enrollment was 35,294, or about 70 percent of Minnesota's full-benefit Medicare-Medicaid enrollees aged 65 or older (Minnesota DHS, 2014). Enrollment in Medicaid managed care is mandatory in Minnesota for this population, unless they meet an exception, such as having a spend down or already being enrolled in the Special Needs BasicCare managed care program. Beneficiary enrollment in MSHO is a voluntary, integrated alternative to mandatory enrollment in a Medicaid-only plan. In

MSHO, beneficiaries receive all Medicare and Medicaid services from one plan with one membership card and have one care coordinator. Benefits include all Medicare services, including Part D; and Medicaid services, including 1915(c) HCBS waiver services and the first 180 days of nursing facility services.

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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 Minnesota demonstration:

- What are the primary areas of Medicare and Medicaid administrative alignment addressed by the Minnesota demonstration?
- What impact have alignment activities under the demonstration had on the State, CMS, MSHO plans and providers?
- To what extent did Minnesota implement the demonstration as planned? What factors contributed to successful implementation? What were the barriers to implementation?
- What State policies, procedures, or practices implemented by Minnesota can inform adaptation or replication by other States?
- What strategies used or challenges encountered by Minnesota can inform adaptation or replication by other States?

3.2 Approach

The evaluation team will examine the alignment activities conducted under the demonstration, their effect on furthering the integration of the Medicare and Medicaid programs and streamlining program administration, factors that facilitated or impeded implementation, and applicability of the administrative changes to efforts of other States. This section will discuss the following:

- Monitoring implementation of the demonstration
- Enrollment indicators
- Data sources
- Interview questions and implementation reports
- Beneficiary experience

3.3 Monitoring Implementation of the Demonstration

Our analysis of the implementation of the Minnesota demonstration will be organized by key demonstration design features that are unique to Minnesota. This framework will be used to define areas of inquiry for the demonstration, structure the demonstration variables that will be tracked, organize information from data collection sources, and outline the annual report. ***Table 5*** illustrates a preliminary understanding of the demonstration's design features and reflects the areas of focus for the demonstration's alignment activities.

Table 5
Demonstration design features and key components for Minnesota

Design feature	Key components
Enrollment	• The State will test new, simplified language on enrollment forms and notices.
Network adequacy	• CMS will conduct a new network review of MSHO plans, testing new standards that will apply existing Medicare Advantage methodology to more accurately reflect the Medicare-Medicaid population. The State will have an opportunity to review the network submissions and provide input to CMS on local delivery systems considerations.
Beneficiary protections from cost sharing	• Through the SNP bidding process, CMS and the State will work with plans to minimize Medicare Advantage and Part D premiums and copays.
Integrated appeals and grievances	• A simplified and integrated model notice for appeals explanations will be developed for CMS approval. The appeal period for Medicare benefits will be extended from 60 days to 90 days to align with the Medicaid timeline.
Contract management	• CMS and the State will develop a process for ongoing monitoring of the demonstration and plan activities.
Quality management	• The State will test adjustments and additions to the existing quality measures required in Medicare Advantage and Medicaid managed care contracts. For example, the State and CMS will work with plans on developing and testing of State-specific measures that could be incorporated into a modified star rating system for MSHO plans and integrated plans in other States. Plans will be required to continue existing star reporting. • The State and CMS will collaborate to streamline the number of CAHPS surveys conducted to reduce burdens on plans and beneficiaries. • CMS and the State will make the HOS available in additional languages, subject to funding availability. • CMS and the State will test approaches to develop appropriate metrics for integrated care, for adapting provider-level measures for use at the plan level, and identifying measures related to community integration. • The State will work with a national consensus-building organization to develop new or revise existing outcome measures (dependent on external funding availability).

(continued)

Table 5 (continued)
Demonstration design features

Design feature	Key components
Performance improvement	• The State will work with CMS and MSHO plans to reduce duplicate reporting requirements for Medicare and Medicaid managed care quality improvement activities, including external quality reviews conducted by the QIO and EQRO. • The State will have input into topics for Medicare Advantage SNP projects on Quality Improvement, Performance Improvement, and Chronic Care Improvement. MSHO plans may use a Medicare format for Medicaid Performance Improvement Projects.
Provider purchasing agreements	• The State will make available to MSHO plans new alternative purchasing arrangements under the Integrated Care System Partnerships, which include the opportunity to integrate Health Care Home model services.
SNP model of care	• The State will have an opportunity to provide input into SNP Model of Care elements for MSHO plans to improve alignment with MSHO requirements and processes.
Marketing, outreach, and education activity	• The State and CMS will work with MSHO plans to align and simplify beneficiary materials, including a summary of benefits, an annual notice of change, combined provider and pharmacy directory, integrated enrollment form, and a member handbook.

CAHPS = Consumer Assessment of Healthcare Providers and Systems; EQRO = External Quality Review Organization; HOS = Health Outcomes Survey; MSHO = Minnesota Senior Health Options; QIO = Quality Improvement Organization; SNP = Special Needs Plan.

NOTE: Some demonstration design features or key components may change with the completion of the work plan.

3.4 Implementation Tracking Elements

Through document review and interviews with State agency staff, RTI will track implementation of the demonstration's alignment activities. Using a combination of case study methods, including document review, and telephone interviews, the RTI evaluation team will conduct a descriptive analysis of the administrative activities planned under the Minnesota demonstration.

The evaluation team will analyze how Minnesota is carrying out its implementation plan and track any changes it makes to its initial design as implementation proceeds. The team will identify both planned changes that are part of the design and operational and policy modifications Minnesota makes based on changing circumstances. Finally, in some instances, changes in the policy environment in the State may trigger alterations to the original demonstration design.

RTI will also collect data from the State to track implementation, including elements from the work plan, through the State Data Reporting System (SDRS); quarterly calls with State demonstration staff; interviews with other stakeholders; and site visits. 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 Minnesota's entries. RTI will make additional calls to State agency staff and key informants as needed to keep abreast of demonstration developments; the team will use site visit interviews to learn more about what factors are facilitating or impeding progress or leading to revisions in the Minnesota demonstration implementation.

3.5 Enrollment Indicators

In addition to tracking implementation of planned administrative changes, the evaluation team will also track enrollment and disenrollment patterns in MSHO, the platform for the demonstration. These data will be reported quarterly by Minnesota 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 SDRS are to serve as a repository for up-to-date information about the Minnesota demonstration design and progress, to capture data elements on a quarterly basis, and to monitor and report on demonstration progress by individual States and the demonstrations as a whole. More detail on the SDRS can be found in the *Aggregate Evaluation Plan* (Walsh et al., 2013).[3]

Table 6 presents a summary of enrollment indicators for the Minnesota demonstration. The list of indicators may be refined in consultation with CMS as needed. RTI will provide training and an instruction manual to assist Minnesota with its SDRS submissions.

Table 6
Examples of enrollment indicators

Indicator
Eligibility
No. of beneficiaries eligible to participate in MSHO
Enrollment
Total no. of beneficiaries currently enrolled in MSHO
No. of beneficiaries newly enrolled in MSHO as of the end of the given month
Disenrollment
No. of beneficiaries who voluntarily disenrolled from MSHO
No. of beneficiaries whose enrollment in MSHO ended involuntarily (e.g., died, moved out of area, lost Medicaid eligibility, were incarcerated)

MSHO = Minnesota Senior Health Options.

[3] Because the Minnesota demonstration is based on the existing MSHO program (i.e., the State is not implementing a managed care model integrating Medicare and Medicaid for the first time), not all aspects of the SDRS data collection described in the *Aggregate Evaluation Plan* will apply.

3.6 Data Sources

The evaluation team will use a variety of data sources to assess whether the Minnesota demonstration was implemented as planned, to identify modifications made to the planned activities, and to determine factors that facilitated implementation or presented challenges. These data sources include the following:

- **State and CMS policies and requirements for plans:** The evaluation team will review a wide range of State-developed documents that specify the Minnesota approach to integrating the Medicare and Medicaid programs. Review of agreements between Minnesota and CMS articulated through the demonstration Memorandum of Understanding, waivers, Special Needs Plan and MSHO Medicaid contracts, and State Plan Amendments will further enhance our understanding of the Minnesota approach.

- **Demonstration data (collected via the SDRS):** Quarterly, RTI will collect data from Minnesota to inform ongoing analysis and feedback to the State and CMS throughout the demonstration. Specifically, the evaluation team will collect information to track the status of policy and administrative changes proposed in the Minnesota demonstration work plan and those subsequently revised or added. We will also collect data on enrollment indicators that are mostly numeric counts of beneficiaries enrolled in MSHO, as illustrated in ***Table 6***. The information collected via the SDRS has been tailored to reflect the unique design of the Minnesota demonstration.

- **State agency staff, stakeholders, selected MSHO plans:** There will be at least two sets of site visits; the first was conducted April 2014 and was designed to collect information on initial implementation activities. Using a three-person team, supplemented with telephone interviews, the evaluation team assessed the following: the perspective of key informants on areas of needed program alignment, successes and challenges in administering an integrated Medicare-Medicaid program, plans for addressing areas of misalignment, rationale for selection of specific alignment activities, and progress to date; internal and external environmental changes; reasons Minnesota 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 the evaluation team will develop a schedule of quarterly telephone interviews with various individuals involved in the demonstration.

  Candidates for key informant interviews on demonstration implementation include, but are not limited to, the following:

  – State officials, such as the following:

    - Assistant Commissioner for Health, Department of Human Services
    - State Medicaid Director
    - Manager, Special Needs Purchasing
    - Manager, Contract Management and Service Development

    - Supervisor, Third Party Administrator Medicare Enrollment Unit
    - Demonstration Project Director
    - Director, Performance Measurement and Quality Improvement
    - Director, Aging and Adult Services Division
    - State Ombudsman for Managed Care
  - Members of the CMS–State Contract Management Team
  - Other CMS staff
  - Representatives from selected MSHO plans
  - Representatives from providers that contract with MSHO plans
  - Consumer advocates

The site visit interview protocol for the initial site visit contained questions specific to the Minnesota demonstration. The process for conducting the second site visit will be comparable. Questions tailored to the key informants in Minnesota will be developed, and topics covered will be provided to the State in advance of the site visit. The RTI team will contact the State to help identify the appropriate individuals to interview. The team will work with the State to schedule the site visit and the on-site interviews and will develop an interview schedule that best suits the needs of State and key informants to be interviewed.

3.7 Analytic Methods

Evaluation of the Minnesota 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. RTI will collect and report quantitative data quarterly as noted in ***Table 6***, ***Examples of Enrollment Indicators***, through the SDRS. The evaluation team will integrate these quantitative data with qualitative data they 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 changes in outcomes related to beneficiaries, quality, utilization, and costs, and enable the RTI team to analyze (1) the changes Minnesota has made to the preexisting outreach efforts, and administrative changes to align Medicare and Medicaid requirements for MSHO plans and enrollees; (2) challenges Minnesota has met; and (3) approaches that can inform adaptation or replication by other States.

4. Outcomes

4.1 Beneficiary Experience

As noted, the Minnesota demonstration focuses on aligning Medicare and Medicaid policies to improve administrative efficiencies and streamline program management at the Federal, State, and plan levels. Most proposed changes will be invisible to the beneficiary, whereas others will offer important but subtle improvements (e.g., combined benefit statements, provider directories, enrollment/disenrollment form) that may not be noticeable to all beneficiaries. The evaluation will explore whether plans have observed changes in beneficiary experience due to administrative simplification

One proposed change, the development of a joint beneficiary survey, will enable the RTI evaluation team to assess whether there are any unintended outcomes in beneficiary experience during the course of the demonstration. CMS and the State intend to administer a single survey based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey instrument. Although it will not be possible to correlate change in experience to specific demonstration activities, survey findings will allow evaluators to track changes over time on items for which there are comparable data.

4.1.1 Overview and Purpose

The evaluation will assess changes over time under the Minnesota demonstration in beneficiary experience. Using mixed methods (i.e., qualitative and quantitative approaches), the evaluation team will monitor and evaluate the experience of beneficiaries. The mixed methods will include the following:

- results of surveys that may be conducted by Minnesota, CMS, or other entities (e.g., CAHPS);
- Minnesota demonstration data and data from other sources submitted via RTI's State Data Reporting System (SDRS; e.g., data on enrollments and disenrollments);
- 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 Minnesota State demonstration staff, consumer advocates, and other key informants during site visits or telephone interviews with RTI.

Through provider and stakeholder interviews, RTI also will explore whether specific demonstration features in Minnesota can be identified that may influence replication in other States. The evaluation team will also collect information from State demonstration staff and CMS or other entities that reflects the beneficiaries' experiences. ***Section 3***, ***Demonstration Implementation Evaluation***, describes topics the team will monitor and document through interviews with Minnesota demonstration staff and document reviews, and the implementation-related research questions for this evaluation.

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 RTI will use these data to inform the team's understanding of the change under the Minnesota demonstration on access to care and health outcomes.

4.1.2 Approach

Table 7 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 the Minnesota demonstration on beneficiary outcomes, including for subpopulations (e.g., those using and not using behavioral health services and LTSS and those residing in nursing facilities and in the community).

Table 7
Demonstration statistics on quality, utilization, and access to care measures of beneficiary experience

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

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

4.1.3 Data Sources

The evaluation team will conduct focus groups with plans and providers to understand the impact of the administrative changes in Minnesota on plans and providers. The focus groups will be designed to capture perspectives on whether the demonstration has led to better integration of the Medicare and Medicaid programs at the State, plan, and provider levels. RTI will also use results of beneficiary surveys planned by the State, CMS, or other entities (e.g., CAHPS); State demonstration data entered into the SDRS; and interviews with State demonstration staff to understand how plans, beneficiaries, and providers are affected by the Minnesota initiative.

4.1.4 Analytic Methods

Most demonstration data will be collected and tracked through the SDRS. The evaluation team will also request any available summary statistics and reports from Minnesota or surveys conducted by CMS or others as applicable. Information from site visits and any additional State-reported data beyond those described specifically in this section also are expected to inform analysis of beneficiary experience research questions.

The evaluation will consider indications of predemonstration beneficiary experience that may be available from other sources. The evaluation will not, however, have predemonstration data or comparison group results in this area. Results will be presented in the annual and final evaluation reports along with available context to inform interpretation.

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

This section is based on our current understanding of the Minnesota demonstration, as outlined above. Although the Minnesota demonstration is focused on administrative simplification, quality, utilization, access, and cost measures will still be monitored to document any changes in outcomes.

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) for the quantitative analyses for the Minnesota 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 are the utilization patterns in acute, long-term, and behavioral health services, for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Do these utilization patterns change over time?
- What is the level of health care quality for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Does health care quality change over time?
- What is the cost of health care for MSHO enrollees overall and for key MSHO subgroups under the Minnesota demonstration? Do these health care costs change over time?
- How do MSHO-eligible full-benefit Medicare-Medicaid enrollees age 65 or older enrolled in MSC+ compare to MSHO enrollees? Does this change over time?
- How do health care quality, utilization, and costs for full-benefit Medicare-Medicaid enrollees aged 65 and older in Minnesota compare to the levels in other States or State groups? Does this change over time?

Results of descriptive analyses focusing on differences across years and key MSHO subgroups on key outcome variables will be included in the Minnesota quarterly reports to CMS and the State and in the annual reports. Multivariate analyses comparing full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota will be included in the final evaluation.

4.2.2 Approach

The Minnesota demonstration combines new administrative flexibilities with changes that have been incorporated in MSHO over many years, continuing the high level of

Medicare/Medicaid integration in the MSHO model. Given that the Minnesota demonstration continues to support those long-term integration efforts, the quantitative analysis will focus on tracking outcomes over time for MSHO enrollees, who are the eligible population for the Minnesota demonstration, as well as key subgroups within that population. To place the Minnesota experience in context, the evaluation will also examine changes in the outcomes of all full-benefit Medicare-Medicaid enrollees aged 65 or older[4] in relation to a similar comparison group from other States. The intent of the analysis is to place the Minnesota experience in the context of other States rather than to test a hypothesis that the Minnesota financing and service delivery model will affect those outcomes because MSHO is an existing program rather than a new financing and service delivery model.

4.2.2.1 Demonstration Evaluation (Finder) Files

To support the quantitative analyses, Minnesota 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 8***). The file will list all of the Medicare-Medicaid enrollees eligible for the demonstration, with additional variables in the file indicating monthly enrollment in the demonstration. Eligible individuals who were not enrolled in the demonstration in a given month will still be part of the evaluation to allow for (1) comparisons with MSHO enrollees and (2) comparisons with other Medicare-Medicaid enrollees aged 65 or older in other States. In addition to indicating who was eligible and enrolled, this file will contain personally identifiable information for linking to Medicare and Medicaid data.

4.2.2.2 Identifying a Comparison Group

To identify geographic areas in other states that are similar to Minnesota, the RTI team will use statistical distance analysis, looking at costs, care delivery arrangements, policy affecting Medicare-Medicaid enrollees, population density, and the supply of medical resources. The specific measures to be used 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, home and community-based services users per 65-and-over Medicaid beneficiary, Personal Care users per 65-and-over Medicaid beneficiary, Medicare Advantage penetration, Medicaid managed care penetration for full-benefit Medicare-Medicaid enrollees, Medicaid-to-Medicare physician fee ratios, population per square mile, and primary care physicians per thousand population. The three LTSS variables capture how areas differ in the settings in which they provide these services. Variation in LTSS 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.

[4] MSHO is also limited to seniors in counties in which there is at least one plan offering MSHO. Currently, all counties in the State have at least one MSHO plan.

Table 8
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 prior to submission to the MDM.
MSIS number	20	CHAR	Alphanumeric	MSIS identification number.
Social security number (SSN)	9	CHAR	Numeric	Individual's SSN.
Sex	1	CHAR	Alphanumeric	Sex of beneficiary (1=male or 2=female).
Person first name	30	CHAR	Alphanumeric	The first name or given name of the beneficiary.
Person last name	40	CHAR	Alphanumeric	The last name or surname of the beneficiary.
Person birth date	8	CHAR	CCYYMMDD	The date of birth (DOB) of the beneficiary.
Person ZIP code	9	CHAR	Numeric	9-digit ZIP code.
Monthly eligibility identification flag	1	CHAR	Numeric	Coded 0 if identified as not eligible for the demonstration, 1 if identified as eligible from administrative data, 2 if identified as eligible from nonadministrative data.
Monthly enrollment indicator	1	CHAR	Numeric	Each monthly enrollment flag variable would be coded 1 if enrolled and 0 if not. Quarterly demonstration evaluation (finder) files would have three such data fields.

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

Once comparison areas are selected, all full-benefit Medicare-Medicaid enrollees aged 65 or older will be selected for comparison group membership. The comparison group will be refreshed annually to incorporate new entrants into the analysis sample as new individuals become full-benefit Medicare-Medicaid enrollees aged 65 or older over time.

In comparing full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota with a comparison group, the evaluation team will have two areas of focus: the first will simply compare the observed levels of quality, utilization, and costs for full-benefit Medicare-Medicaid enrollees aged 65 or older in other areas with the levels observed for full-benefit Medicare-Medicare enrollees aged 65 or older in Minnesota; the second will seek to control for differences in the characteristics of the full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota and the comparison groups to provide an descriptive assessment of differences in the levels of quality, utilization, and costs that would be expected for full-benefit Minnesota Medicare-Medicaid enrollees aged 65 or older *if* they lived in those other areas. To ensure that the comparison group for the latter comparison is similar to the full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota, the evaluation team will compute propensity scores and weight comparison group beneficiaries using the framework described in ***Section 4.2.2.4*** of this report.

4.2.2.3 Issues/Challenges in Identifying Comparison Groups

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

1. **Similarities between demonstration and comparison groups:** Comparison group members are as much like demonstration group members as possible, and sufficient data are needed to identify and control for differences. Although the comparison areas will be selected based on similarities to Minnesota (as described above), further criteria may be included, such as areas with or without integrated Medicare-Medicaid programs. Final criteria will be developed in discussions with CMS.

2. **Sample size:** Given that the team plans to use all full-benefit Medicare-Medicaid enrollees aged 65 or older in the comparison areas, we expect to have sufficient sample size for the statewide analyses.

3. **Accounting for enrollment in other demonstrations:** Some full-benefit Medicare-Medicaid enrollees aged 65 or older may not be suitable for comparison group selection because of participation in other demonstrations or enrollment in Accountable Care Organizations. RTI will work with CMS to specify these parameters and apply them to both Minnesota and the comparison group.

4. **Medicaid data:** Significant delays currently exist in obtaining Medicaid data from many States. If unaddressed, this problem could result in delays in formulating appropriate comparison groups. Timeliness of Medicaid Statistical Information System (MSIS) data submissions will need to be considered when selecting out-of-State comparison areas.

4.2.2.4 Propensity Score Framework for Identifying Comparison Group Members

The comparison group in Minnesota is intended to support a descriptive comparison of the quality, cost, and utilization of services in Minnesota to similar individuals in other States rather than to test a hypothesis that the Minnesota financing and service delivery model will affect those outcomes because MSHO is an existing program, not a new financing and service delivery model. Because comparison group members may differ from the demonstration group on individual characteristics, the evaluation team will compute propensity scores for the demonstration and comparison group members. The propensity score represents how well a combination of characteristics, or covariates, predicts that a beneficiary is in the demonstration group. To compute these scores for beneficiaries in the demonstration and comparison groups, the team will first identify beneficiary-level and market-level characteristics to serve as covariates in the propensity-score model. Beneficiary-level characteristics may include demographics, socioeconomic, health, and disability status; and county-level characteristics may include health care market and local economic characteristics. Once the scores are computed, RTI 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 9 provides an overview of the data sources to be used in the Minnesota evaluation of quality, utilization, and cost. Data sources include Medicare and Medicaid fee-for-service (FFS) data, Medicare Advantage encounter data, and MSHO Plan encounter data. These data will be used to examine changes in quality, utilization, and cost over the demonstration period. Data will be needed for all full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota and in the comparison areas. Note that data requirements for an individual beneficiary will depend on whether the person was in Medicare FFS or Medicare Advantage in the pre- and postdemonstration periods.

The terms of the Minnesota MOU require the State to provide timely Medicaid data through MSIS. 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 9
Data sources to be used in the Minnesota evaluation analyses of quality, utilization, and cost

Aspect	Medicare fee-for-service data	Medicaid fee-for-service data	Encounter data[1]
Obtained from	CMS	CMS	CMS
Description and uses of data	Will be pulled from ● Part A (hospitalizations) ● Part B (medical services) Will be used to evaluate quality of care, utilization, and cost during the demonstration. These data will also be used for beneficiaries who have disenrolled from MSHO or do not enroll; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups.	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 have disenrolled from MSHO or do not enroll; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups.	Pre- and postperiod 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 have disenrolled from MSHO or do not enroll; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups.
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 9 (continued)
Data sources to be used in Minnesota 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 managed care plans are required to submit encounter data to CMS for all demonstration years.
Potential concerns	—	Potential time delay for 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; MSHO = Minnesota Senior Health Options; MSIS = Medicaid Statistical Information System; NCH = National Claims History; TAP = monthly Medicare claims files.

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

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

4.3 Analyses

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

- a monitoring analysis to track changes in selected quality, utilization, and cost measures over the course of the Minnesota demonstration for MSHO enrollees and subgroups of MSHO enrollees (as data are available);
- a descriptive analysis of quality, utilization, and cost measures for MSHO enrollees for annual reports, with means and comparisons for MSHO subgroups of interest and for MSHO-eligible full-benefit Medicare-Medicaid enrollees age 65 or older in MSC+ in Minnesota; and
- a descriptive analysis of quality, utilization, and cost measures for all full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota for annual reports, with means and comparisons for out-of-State comparison groups of full-benefit Medicare-Medicaid enrollees aged 65 or older; and
- multivariate analyses of quality, utilization, and cost measures for full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota using an out-of-State comparison group. As noted above, the intent of this analysis is to monitor the quality, cost, and utilization of services in Minnesota rather than to test a hypothesis that the Minnesota financing and service delivery model will affect those outcomes because MSHO is an existing program, not a new financing and service delivery model.

The approach to each of these analyses is outlined below in ***Table 10***, and more detail is provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013). The activities for the analyses may be revised if modifications are made to the demonstrations or if data sources are not available as anticipated. If modifications to this evaluation plan are required, they will be documented in the annual and final evaluation reports as appropriate.

4.3.1 Monitoring Analysis

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

Table 10
Quantitative analyses to be performed for Minnesota demonstration

Aspect	Monitoring analysis	Descriptive analysis	Multivariate analyses
Purpose	Track changes in selected quality, utilization, and cost measures over the course of the demonstration.	Provide estimates of quality, utilization, and cost measures on an annual basis.	Measure changes in quality, utilization, and cost measures over time.
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 comparisons using demonstration and comparison groups.
Reporting frequency	Quarterly to CMS and the State	Annually	Once, in the final evaluation.

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

The goal of these analyses is to monitor and track changes in quality, utilization, and costs under MSHO. Though these 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.

4.3.2 Descriptive Analysis of Quality, Utilization, and Cost Measures

RTI will conduct a descriptive analysis of quality, utilization, and cost measures for the Minnesota demonstration annually for each performance period that includes means, counts, and proportions for the (1) MSHO enrollees, (2) MSHO-eligible full-benefit Medicare-Medicaid enrollees aged 65 or older enrolled in MSC+, (3) full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota and (4) full-benefit Medicare-Medicaid enrollees aged 65 or older in the comparison groups. This analysis will focus on estimates for a broad range of quality, utilization, and cost measures, as well as changes in these measures across years. Separate analyses will be conducted for MSHO 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, the evaluation team will develop separate (unlinked) encounter, Medicare, and Medicaid beneficiary-level analytic files annually to measure quality, utilization, and cost. Though the Medicare, Medicaid, and encounter data will not be linked, the unlinked beneficiary-level files will still allow for an understanding of trends in quality, utilization, and cost measures. The analytic files will include data from the predemonstration period and for each demonstration year. Because of the longer expected time lags in the availability of Medicaid data, Medicare FFS data and Medicare encounter data may be available sooner than Medicaid FFS data. Therefore, the first annual report is expected to include predemonstration Medicare and Medicaid FFS data and Medicare FFS, Medicare Advantage, and managed care plan encounter data for the demonstration period. Medicaid FFS data will be incorporated into later reports as the data become available.

The RTI team will measure predemonstration and annual utilization rates and costs of Medicare- and Medicaid-covered services together, where appropriate, to look at any changes in the type and level of service use during the Minnesota demonstration. The team 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. The team will adjust for hospitalizations in the prior year using categorical HCC scores or similar measures. Chi-square and *t*-tests will be used to test for significant differences in use across years and between subpopulations.

4.3.3 Multivariate Analyses of Quality, Utilization, and Cost Measures

In the final year of the evaluation, RTI will compare trends over time in Minnesota for full-benefit Medicare-Medicaid enrollees aged 65 or older with similar individuals in the comparison group. These comparisons will include both simple comparisons and comparisons based on propensity-score weighting methods to control for differences in the full-benefit Medicare-Medicaid enrollees 65 or older in Minnesota and the comparison group. These comparisons will be conducted for each quality, utilization, and cost outcome described in the next section for the final evaluation. The analytic approaches are described in greater detail in the *Aggregate Evaluation Plan* (Walsh et al., 2013). As noted above, the intent of this analysis is to place the quality, cost, and utilization of services in Minnesota in the context of other States rather than to test a hypothesis that the Minnesota financing and service delivery model will affect those outcomes because MSHO is an existing program rather than a new financing and service delivery model.

4.3.4 Subpopulation Analyses

For MSHO subpopulations of focus in the Minnesota demonstration, the RTI team will evaluate trends in quality, utilization, and access to care for medical, LTSS, and behavioral health services for MSHO enrollees; the team will also examine qualitative data gathered through interviews and surveys. Descriptive analyses for annual reports will present results on selected measures stratified by MSHO subpopulations (e.g., those using and not using behavioral health services and LTSS and those residing in nursing facilities and in the community).

4.4 Utilization and Access to Care

Claims and encounter data from Medicare and Medicaid 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 11***). Note that ***Table 11*** indicates the sources of data for these analyses during the demonstration.

The evaluation team anticipates being able to develop traditional utilization measures for each of the service classes in ***Table 11*** (e.g., various inpatient use rates based on diagnoses of interest).

Table 11
Service categories and associated data sources for reporting utilization measures

Service type	Encounter data (Medicare Advantage and MSHO enrollees)	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 (Personal Care, waiver services)	X	X	—
Dental	X	X	—

— = not available; FFS = fee for service; HCBS = home and community-based services; MSHO = Minnesota Senior Health Options.

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

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

4.5 Quality of Care

The RTI team will monitor a core quality measure set to understand the experiences of beneficiaries enrolled in the Minnesota demonstration. Quality measures have multiple data sources: claims and encounter data, which RTI will obtain and analyze for evaluation measures listed in ***Table 12***; and information collected by Minnesota, CMS, or others and provided in aggregate to the RTI team for inclusion in reports. The latter may include Healthcare Effectiveness Data and Information Set (HEDIS) measures reported by MSHO plans and beneficiary survey data collected by Minnesota, CMS, or other entities (e.g., CAHPS).

Table 12 provides a working list of the core quality measures to be included in the evaluation of the Minnesota demonstration. The table specifies the measure, the source of data for the measure, whether the measure is intended to produce estimates of changes over time, as well as a more detailed definition and specification of the numerator and denominator for the measure. RTI will also identify a few additional measures specific to the Minnesota demonstration. The data for these measures will be available through claims and encounter data that RTI will obtain from CMS; they will not require additional State or MSHO plan reporting. These measures will be finalized within the first year of implementation.

Finally, the evaluation will analyze MSHO subgroups of interest, as appropriate, and look at measures that might be particularly relevant to them (e.g., measures that might be specific to people with developmental disabilities or behavioral health conditions).

Table 12
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 estimates of changes over time?[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 postdischarge.
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 12 (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 estimates of changes over time?[1]	Definition (link to documentation if available)	Numerator/denominator description
Immunizations (cont'd) Pneumococcal vaccination for patients 65 years or older	Claims/encounter RTI will acquire and analyze	Prevention	Yes	Percentage of demonstration-eligible patients aged 65 years or older who have ever received a pneumococcal vaccine.	Numerator: Demonstration-eligible Medicare-Medicaid enrollees aged 65 or older who have ever received a pneumococcal vaccination. Denominator: All demonstration-eligible Medicare-Medicaid enrollees aged 65 years or older, excluding those with documented reason for not having one.
ACSC admission ACSC 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 ACSCs among demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older. Conditions include diabetes—short-term complications; diabetes—long-term complications; COPD; HTN; 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.
ACSC 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; HTN; 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 12 (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 estimates of changes over time?[1]	Definition (link to documentation if available)	Numerator/denominator description
Admissions with primary diagnosis of a severe and persistent mental illness or substance use disorder	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of demonstration-eligible Medicare-Medicaid enrollees with a primary diagnosis of a severe and persistent mental illness or substance use disorder who are hospitalized.	Numerator: Total number of acute-care hospitalizations among demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older with a primary diagnosis of a severe and persistent mental illness or substance use who are hospitalized. Denominator: Demonstration-eligible Medicare-Medicaid enrollees, aged 18 or older.
Avoidable ED 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.
ED 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 ED 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 12 (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 estimates of changes over time?[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 or 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 aged 65 years or older.

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Table 12 (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 estimates of changes over time?[1]	Definition (link to documentation if available)	Numerator/denominator description
Cardiac Rehabilitation CR 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 CR/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 CR 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 12 (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 estimates of changes over time?[1]	Definition (link to documentation if available)	Numerator/denominator description
Treatment of alcohol and substance use disorders Initiation and engagement of alcohol or other drug (AOD) 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 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 or older who were diagnosed with a new episode of alcohol and drug dependency during the intake period of January 1–November 15 of the measurement year. EXCLUSIONS: Exclude those who had a claim/encounter with a diagnosis of AOD during the 60 days before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service.
Depression screening and follow-up Screening for clinical depression and follow-up	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of patients aged 18 or 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 or older with certain exceptions (see source for the list).

(continued)

Table 12 (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 estimates of changes over time?[1]	Definition (link to documentation if available)	Numerator/denominator description
Blood Pressure Controlling high BP	Medical records (HEDIS EOC035)	Prevention, care coordination	No	Percentage of members aged 18–85 who had a diagnosis of HTN and whose BP 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 HTN. 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.

(continued)

Table 12 (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 estimates of changes over time?[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 12 (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 estimates of changes over time?[1]	Definition (link to documentation if available)	Numerator/denominator description
Medication management Annual monitoring for patients on persistent medications	Medical records (HEDIS EOC075)	Care coordination	No	Percentage who received at least 180 treatment days of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year. Agents measured: (1) ACE inhibitors or ARB, (2) digoxin, (3) diuretics, (4) anticonvulsants.	Numerator: Number with at least 180 days of treatment AND a monitoring event in the measurement year. Combined rate is sum of 4 numerators divided by sum of 4 denominators. Denominator: Demonstration participants with at least 180 days of treatment in the year for a particular agent.

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

[1] 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 May 27, 2015.

4.6 Cost

To determine annual total costs (overall and by payer) for MSHO enrollees and for full-benefit Medicare-Medicaid enrollees aged 65 or older in Minnesota, the evaluation team will aggregate the Medicare and Medicaid PMPM payments to the managed care plans and any FFS Medicare and Medicaid payments. RTI will include Part D PMPM and any PMPM reconciliation data provided by CMS in the final estimates of changes in costs to ensure that all data are available.

To the extent possible, the evaluation will analyze cost data for the service types shown in ***Table 11*** in the previous section on utilization with the addition of prescription drug costs. As with quality and utilization analyses, the analyses presented in the annual report will include a comparison group to provide context for the Minnesota estimates. The evaluation will also present results for key MSHO subgroups to better understand their demonstration experience. As noted above, this analysis is not intended to test a hypothesis that the Minnesota financing and service delivery model will affect costs because MSHO is an existing program, not a new financing and service delivery model.

4.7 Analytic Challenges

Obtaining Medicaid FFS and managed care plan encounter data will be critical for the evaluation, so it will be important that Medicaid encounter data be provided 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/Transformed MSIS submissions.

5. References

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