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

Washington Managed Fee-for-Service Evaluation Design Plan

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Executive Summary

Washington is implementing a managed fee-for-service (MFFS) model demonstration, known as HealthPath Washington Strategy 1, under the Financial Alignment Initiative, leveraging health home services to coordinate care for high-cost/high-risk full-benefit Medicare-Medicaid enrollees.[1] Washington's two Medicaid State Plan Amendments to establish health homes under Section 2703 of the Affordable Care Act were approved by CMS with effective dates of July 1, 2013, and October 1, 2013 (Washington State Health Care Authority [HCA], 2013a, 2013b). The MFFS demonstration is statewide, except for two counties where the State plans to implement a capitated model demonstration in 2014. The MFFS demonstration began July 1, 2013, and will continue until December 31, 2016 (Centers for Medicare & Medicaid Services [CMS] and State of Washington, 2012, p. 4; hereafter, MOU, 2012; CMS and State of Washington, 2013, p. 8; hereafter, Agreement, 2013).

CMS contracted with RTI International to monitor the implementation of demonstrations under the Financial Alignment Initiative, and to evaluate their impact on beneficiary experience, quality, utilization, and cost. The evaluation includes an aggregate evaluation and State-specific evaluations. This report describes the State-specific Evaluation Plan for the Washington MFFS demonstration as of May 13, 2014. The evaluation activities may be revised if modifications are made to either the Washington MFFS demonstration or to the activities described in the *Aggregate Evaluation Plan* (Walsh et al., 2013). Although this document will not be revised to address all changes that may occur, the annual and final evaluation reports will note areas where the evaluation as executed differs from this evaluation plan.

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

The principal focus of the evaluation will be at the demonstration level. CMS has engaged an operations support contractor and established other mechanisms to monitor fulfillment of the demonstration requirements outlined in the Memorandum of Understanding (MOU) and Final Demonstration Agreement (MOU, 2012; Agreement, 2013). RTI will integrate that information into the evaluation as appropriate.

[1] "Full-benefit Medicare-Medicaid enrollees" refers to individuals who are eligible for Medicare and for full Medicaid benefits. "Partial Medicare-Medicaid enrollees" refers to individuals who receive only Medicare premium assistance and cost-sharing assistance from Medicaid.

Table ES-1
Research questions and data sources

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

— = not applicable; MFFS = managed fee for service.

[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 health homes.

Demonstration Implementation. Evaluation of demonstration implementation will be based on case study methods and quantitative data analysis of service utilization patterns. We will monitor progress and revisions to the demonstration, and will identify transferable lessons from the Washington MFFS demonstration through the following: document review, ongoing submissions by the State through an online State Data Reporting System (e.g., eligibility and loss of eligibility statistics and qualitative updates on key aspects of implementation), quarterly key

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

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

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

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

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

home services, and a group of similar individuals in the comparison group. This approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration-eligible population. RTI will compare the characteristics of those who enroll in health homes with those who are eligible but do not enroll and will conduct analyses to further explore demonstration effects on health home enrollees, acknowledging that selection bias must be taken into account in interpreting the results.

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

Identifying the comparison group members will entail two steps: (1) selecting the geographic area from which the comparison group will be drawn and (2) identifying the individuals who will be included in the comparison group. Because Washington has implemented its demonstration statewide (except for two counties that will participate in a capitated model demonstration under the Financial Alignment Initiative), we will consider a comparison group from out-of-State Metropolitan Statistical Areas (MSAs). We will use cluster analysis to identify potential comparison States and areas that are most similar to Washington in regard to costs, care delivery arrangements, and State policy affecting Medicare-Medicaid enrollees.

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

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

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

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

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

reports. This analysis will focus on estimates for a broad range of quality, utilization, and cost measures, as well as changes in these measures across years or subgroups of interest within each year.

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

4. A calculation of savings after each demonstration period, using an actuarial methodology for performance payment purposes. This methodology is described in the Washington MFFS MOU and Final Demonstration Agreement (MOU, 2012; Agreement, 2013). The evaluation will also use a regression-based approach to examine savings at the end of the demonstration.

Subpopulation Analyses. For subpopulations of focus in the Washington MFFS demonstration, we will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and behavioral health services and will also examine qualitative data gathered through interviews, focus groups, and surveys. Descriptive analyses for annual reports will present results on selected measures stratified by subpopulations (e.g., those using and not using health home services, behavioral health services, LTSS). Multivariate analyses performed for the final evaluation will account for differential effects for subpopulations in specification testing by using dummy variables for each of the specific subpopulations of interest one at a time so that the analyses can suggest whether quality, utilization, and cost are higher or lower for each of these groups.

Because engagement in the health home model is voluntary, not all eligible beneficiaries will receive the health home services available to them. Thus, one set of subgroup analyses will compare the characteristics and key outcomes of eligible beneficiaries who receive different levels of health home services, ranging from no use to intensive use. We will also divide groups based on the amount of time enrolled in a health home. The definitions of these levels will be made once distributions of intensity of use become clear. These analyses may include both univariate and multivariate methods.

Utilization and Access to Care. Medicare and Medicaid data will be used to evaluate changes in the levels and types of services used, ranging along a continuum from institutional care to care provided at home and including changes in the percentage of enrollees receiving supports in the community or who reside in institutional settings (see ***Table 15*** of this report for more detail). Because Medicaid health home services are a key part of the demonstration, we will examine the individual and market factors associated with the use of these services.

Quality. Across all demonstrations, RTI will evaluate a core quality measure set for monitoring and evaluation purposes that are available through claims and encounter data.[2] RTI

[2] 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 impact 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.

will obtain these data from CMS (see ***Table 16*** of this report). We will supplement these core measures with the following:

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

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

Cost Savings. Washington will be eligible for performance payments from CMS based on achieving statistically significant Medicare savings based on annual actuarial savings calculations performed by RTI. The savings calculations will reflect Medicare savings net of increased Federal Medicaid spending. The methodology for the savings calculations is described in the Washington MFFS MOU and Final Demonstration Agreement (MOU, 2012; Agreement, 2013). The results of the RTI savings calculations will be used by CMS or another contractor to determine whether the State is eligible for a performance payment and if so, the amount of that payment. RTI will also use a multivariate regression-based approach for the final evaluation report to determine the impact of the demonstration on Medicare and Medicaid costs; this calculation will include Medicaid, Medicare Parts A and B, and Medicare Part D costs, as well as any performance payment made to the State as part of the demonstration.

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

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

RTI will obtain data from:	Type of Data
CMS	● Medicare and Medicaid fee-for-service claims ● Medicare Part D costs ● Nursing facility data (MDS) ● Encounter data[1] (Medicare Advantage, Medicaid) ● CMS-HCC and RXHCC risk scores ● Demonstration quality measures that Washington is required to report to CMS (listed in MOU) ● Other administrative data as available

(continued)

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

RTI will obtain data from:	Type of Data
State	● Detailed description of State's method for identifying eligible beneficiaries ● File with monthly information identifying beneficiaries eligible for the demonstration (can be submitted monthly or quarterly)[1] ● SDRS (described in detail in Section 4 of the *Aggregate Evaluation Plan*) quarterly submissions of demonstration updates, including monthly statistics on enrollments, opt-outs, and disenrollments ● Participation in key informant interviews and site visits conducted by RTI team ● Results from surveys, focus groups, or other evaluation activities (e.g., EQRO or Ombuds reports) conducted or contracted by the State,[2] if applicable ● Other data State believes would benefit this evaluation, if applicable
Other sources	● Results of focus groups conducted by RTI subcontractor (Henne Group) ● Grievances and appeals ● Other sources of data, as available

EQRO = external quality review organization; HCC = hierarchical condition category; MDS = Minimum Data Set; MOU = Memorandum of Understanding (MOU, 2012); RXHCC = prescription drug hierarchical condition category; SDRS = State Data Reporting System.

[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 impact 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.

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

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

References

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1. Introduction

1.1 Purpose

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

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

This report describes the State-specific Evaluation Plan for the Washington managed fee-for-service (MFFS) demonstration, known as HealthPath Washington Strategy 1, as of May 13, 2014. The evaluation activities may be revised if modifications are made to either the Washington MFFS 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 Washington MFFS demonstration and provides detailed information on the framework for quantitative and qualitative data collection; the data sources, including data collected through RTI's State Data Reporting System (described in detail in the *Aggregate Evaluation* Plan [Walsh et al., 2013]); and impact and outcome analysis (i.e., the impact on beneficiary experience and quality, utilization, access to care, and costs) that will be tailored to the Washington MFFS demonstration.

1.2 Research Questions

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

Unless otherwise referenced, the summary of the Washington MFFS demonstration is based on the Memorandum of Understanding (MOU) between CMS and the State (Centers for Medicare and Medicaid Services [CMS] and the State of Washington, 2012; hereafter, MOU, 2012); the Final Demonstration Agreement between CMS and the State, signed on June 28, 2013 (CMS and the State of Washington, 2013; hereafter, Agreement, 2013); the Washington Health Home State Plan Amendments (SPAs), approved by CMS with effective dates of July 1, 2013, and October 1, 2013 (Washington State Health Care Authority [HCA], 2013a, 2013b; hereafter, SPA, 2013a and 2013b); the Washington MFFS demonstration proposal submitted to CMS on April 26, 2012 (Washington Department of Social and Health Services [DSHS] and HCA, 2012;

hereafter, Washington proposal); and discussions and e-mail communications with MMCO staff at CMS and with State staff regarding the Washington MFFS demonstration as of April 11, 2014. A separate evaluation plan will be developed for the Washington capitated model demonstration. The details of the evaluation design are covered in the three major sections that follow:

- An overview of the Washington managed fee-for-service demonstration
- Demonstration implementation, evaluation, and monitoring
- Impact and outcome evaluation and monitoring.

Table 1
Research questions and data sources

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

(continued)

Table 1 (continued)
Research questions and data sources

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

— = not applicable; MFFS = managed fee for service.

[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 impact 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.

[2] 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 health homes.

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2. Washington Managed Fee-for-Service Demonstration

2.1 Demonstration Goals

The goals of the Washington managed fee-for-service (MFFS) demonstration are to integrate care for Medicare-Medicaid enrollees, alleviate fragmentation, and improve coordination of services for high-cost, high-risk Medicare-Medicaid enrollees served primarily in fee-for-service systems of care, improve beneficiary outcomes, and reduce overall cost over time for the State and the Federal government. Key objectives of the demonstration are to improve beneficiary experience in accessing care, promote person-centered health action planning, promote independence in the community, improve quality of care, assist beneficiaries in getting the right care at the right time and place, reduce health disparities, improve transitions among care settings, and achieve cost savings for the State and the Federal government through improvements in health and functional outcomes (MOU, 2012, p. 4; Agreement, 2013, p. 3).

2.2 Summary of Demonstration

Washington is implementing an MFFS demonstration, known as HealthPath Washington Strategy 1, leveraging health home services to coordinate care for high-cost, high-risk full-benefit Medicare-Medicaid enrollees.[3] Washington's two Medicaid State Plan Amendments (SPAs) to establish health homes under Section 2703 of the Affordable Care Act (Patient Protection and Affordable Care Act of 2010) were approved by CMS with effective dates of July 1, 2013, and October 1, 2013 (SPA, 2013a, 2013b). The MFFS demonstration is statewide, except for the two counties where the State plans to implement a capitated model demonstration under the Financial Alignment Initiative in 2014. The MFFS demonstration began July 1, 2013, and will continue until December 31, 2016 (MOU, 2012, p. 4; Agreement, 2013, p. 8).

Eligibility for the MFFS demonstration includes Medicare-Medicaid enrollees of all ages who live in counties where the demonstration is being implemented; do not have other comprehensive health insurance; are not enrolled in Medicare Advantage, Program of All-Inclusive Care for the Elderly (PACE), or receiving hospice services; and meet the State's health home eligibility criteria, as detailed below (MOU, 2012, pp. 9–10). All Medicare-Medicaid beneficiaries who are eligible for the demonstration will be enrolled in a health home, unless they opt out prior to health home enrollment, and subject to the capacity of the health homes. Washington also provides health home services to Medicaid-only beneficiaries, but health home services are provided to Medicare-Medicaid enrollees only through the demonstration. Beneficiaries are eligible for Medicaid State Plan health home services in Washington if they have one of the chronic conditions listed in the health home SPAs and are at risk of developing another.[4] Washington defines "at risk of developing another chronic condition" using the State's

[3] "Full-benefit Medicare-Medicaid enrollees" refers to individuals who are eligible for Medicare and for full Medicaid benefits. "Partial Medicare-Medicaid enrollees" refers to individuals who receive only Medicare premium assistance and cost-sharing assistance from Medicaid.

[4] The chronic conditions listed in the Washington SPA are as follows: mental health condition; substance abuse disorder; asthma; diabetes; heart disease; cancer; cerebrovascular disease; chronic respiratory conditions; coronary artery disease; dementia or Alzheimer's disease; gastrointestinal; hematological conditions; HIV/AIDS; intellectual disability or disease; musculoskeletal conditions; neurological disease; and renal failure.

Predictive Risk Intelligence System (PRISM), a Web-based clinical decision support tool that generates predictive risk scores based on Medicare and Medicaid claims data. Washington's health home SPAs state that a minimum predictive PRISM risk score of 1.5 is required for a beneficiary to be considered "at risk." This score means that individuals are predicted to have medical expenditures over the next 12 months that are 50 percent greater than average for the base reference group, which is the Washington SSI disability population (SPA, 2013a, pp. 9–10; Agreement, 2013, pp. 5–6).

For individuals who have less than the 15 months of electronic claims history needed to generate a PRISM score, Washington uses a tool to manually determine medical eligibility based on chronic conditions (SPA, 2013a, p. 10). Health homes enter an individual's chronic conditions and medications into the tool, which then calculates the risk score. If the score is 1.5 or greater, the score is submitted to the Health Care Authority, which performs further analysis to confirm eligibility (SPA, 2013a, p. 10; Agreement, 2013, p. 6).

Health home lead entities (hereafter referred to as health homes) are under contract with the State for administration of health home services, which are primarily varying forms of care coordination. Types of organizations designated as health homes in Washington include managed care organizations, consortia of providers, and area agencies on aging. Health homes collect and submit health home service encounters; monitor quality of health home services; report on financial, health status, performance, and outcome measures; and provide customer service (SPA, 2013a, p. 22).

Health homes provide health home services to enrollees in two ways: (1) directly and (2) by assigning an enrollee to a Care Coordination Organization (CCO) for provision of the services. Each health home is expected to subcontract with a diverse group of CCOs representing primary care, mental health, long-term services and supports (LTSS), chemical dependency, and specialty providers, and must include the local agencies that authorize Medicaid and other publicly funded services. This diversity is intended to ensure that each health home has experience among its affiliates to engage enrollees with diverse service needs and coordinate their health care and other services. CCOs are accountable for care coordination staffing and direct oversight of health home service delivery (SPA, 2013a, pp. 22–23).

The State enrolls demonstration-eligible individuals into one of the qualified health homes in their region, based on zip code and health home capacity, with the exception of American Indian/Alaska Native individuals; they may choose to enroll in a health home but are not automatically enrolled. After enrollment, the health home lead entity assigns each beneficiary to one of its affiliated CCOs, which assigns the beneficiary to a care coordinator (SPA, 2013a, p. 11).

Care coordinators contact beneficiaries and offer health home services. If the beneficiary agrees, a home visit is scheduled and information is mailed to the beneficiary. During the home visit, a person-centered Health Action Plan is completed to identify and document the beneficiary's goals and what the beneficiary intends to do to improve his or her health. Completing the Health Action Plan confirms the individual's consent to receive health home services. Beneficiaries can change CCOs within the health home network, or discontinue health home services at any time (MOU, 2012, p. 11; SPA, 2013a, p. 49).

The State pays for health home services on a per member per month (PMPM) basis, with three payment tiers. Monthly payments are made only for months in which an encounter is submitted by the health home. The first month's payment is a one-time fee of $252.93 for outreach and engagement, health screening and assessment, assessment for self-management, and development of the enrollee's Health Action Plan. After the health home has submitted an enrollee's Health Action Plan, in succeeding months it can submit encounters for either intensive or low-level services. The rate for intensive care coordination is $172.61. For any month in which only low-level care coordination was provided to an enrollee, the health home is paid $67.50 (SPA, 2013a, pp. 27–49).

The administrative functions of health homes are financed through a 10 percent withhold from the PMPM care coordination payments. An additional 2 percent of the intensive and low-level payments is withheld for an incentive pool, with performance incentives payable to health homes for meeting health home program goals. The full PMPM payments will be made to all health homes the first year. In the second year, payment will be reduced by up to 2 percent for health homes that fail to meet target levels of beneficiary engagement, as indicated by the percentage of enrolled beneficiaries with completed Health Action Plans (SPA, 2013a, p. 29). ***Table 2*** provides a summary of the key characteristics of the Washington MFFS demonstration compared with the predemonstration system for demonstration-eligible beneficiaries.

Table 2
Key features of the Washington MFFS model, predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Summary of covered benefits		
Medicare	Medicare Parts, A, B, and D	Medicare Parts A, B, and D
Medicaid	Medicaid State Plan	Medicaid State Plan plus health home services
Payment method (capitated/FFS/MFFS)		
Medicare	FFS	FFS
Medicaid (capitated or FFS)		
Primary/medical	FFS	FFS
Behavioral health	Capitated managed care —PIHPs	Capitated managed care—PIHPs
LTSS (excluding HCBS waiver services)	FFS	FFS
HCBS waiver services	FFS	FFS

(continued)

Table 2 (continued)
Key features of the Washington managed fee-for-service model predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Care coordination/case management		
Care coordination for medical, behavioral health, or LTSS and by whom	Medical care coordination was not available to Medicare-Medicaid enrollees in FFS. LTSS case management was provided by area agencies on aging. Mental health services provided through the Regional Support Networks included rehabilitation case management.	Health home care coordinators coordinate medical, behavioral, and LTSS, in collaboration with agencies that currently provide case management for LTSS and mental health services.
Care coordination/case management for HCBS waivers and by whom	HCBS waiver case management for older people and adults with physical disabilities was provided by area agencies on aging; for persons with developmental disabilities, it was provided by the State Division of Developmental Disabilities.	HCBS waiver case management continues to be provided by area agencies on aging, and the State Division of Developmental Disabilities. Health home care coordinators coordinate with the HCBS waiver case managers.
Rehabilitation Option services	Regional Support Networks provided mental health rehabilitation case management.	Regional Support Networks continue to provide mental health rehabilitation case management.
Clinical, integrated, or intensive care management (indicate any changes)	None	Health homes
Enrollment/assignment		
Enrollment method, if applicable	N/A	The Medicaid agency assigns eligible individuals to a health home serving their region based on zip code and provider capacity, which will conduct outreach and enrollment. Individuals will confirm their enrollment in a health home by completing a Health Action Plan.
Attribution/assignment method, if applicable	N/A	N/A
Implementation		
Geographic area	N/A	Statewide, depending on provider capacity and readiness, except for two counties where the State will implement a capitated model demonstration under the Financial Alignment Initiative.

(continued)

Table 2 (continued)
Key features of Washington managed fee-for-service model predemonstration and during the demonstration

Key features	Predemonstration	Demonstration[1]
Phase-in plan	N/A	The State is enrolling beneficiaries into health homes in phases, based on health homes' capacity to engage enrollees.
Implementation date	N/A	July 1, 2013

FFS = fee for service; HCBS = home and community-based services; LTSS = long-term services and supports; MFFS = managed fee for service; MMIS = Medicaid Management Information System; N/A = not applicable; PIHP = Prepaid Inpatient Health Plan.

[1] Information related to the Demonstration in this table is from the Memorandum of Understanding (MOU, 2012); the approved Health Home State Plan Amendments, effective July 1, 2013, and October 1, 2013 (SPA, 2013a, 2013b); the Final Demonstration Agreement (Agreement, 2013); and the State's demonstration proposal (Washington proposal, 2012).

The State estimates that approximately 18,000 high-risk, high-cost Medicare-Medicaid enrollees are eligible for the demonstration (communications with Washington Department of Social & Health Services (DSHS), March 2014). Service utilization patterns of all Medicare-Medicaid enrollees in the State who meet the health home medical eligibility criteria are presented in ***Table 3***. Washington estimates that in State fiscal year (SFY) 2009, 44,608 Medicare-Medicaid enrollees (36 percent of the 122,836 total Medicare-Medicaid enrollees), residing in all parts of the State, met the State's medical eligibility criteria for health home services. These data include those living in the two counties that are not participating in the MFFS demonstration and others who may not be eligible for the MFFS demonstration because of enrollment in other programs. Although the risk-scoring algorithm used to identify high-risk, high-cost enrollees is based primarily on medical conditions and costs, 90 percent of high-risk, high-cost Medicare-Medicaid enrollees also use LTSS, mental health services, alcohol and drug use treatment, and/or developmental disability services, as shown below (Washington proposal, 2012, pp. 47–48).

Table 3
Service use of high-risk, high-cost Medicare-Medicaid enrollees statewide for SFY 2009

Type of service	No. of Medicare-Medicaid enrollees using service	Percentage of Medicare-Medicaid enrollees
Use only developmental disabilities (DD) services	877	2%
Use only mental health services (MH) for severe and persistent mental illness	1,356	3%
Use only alcohol and other dependency (AOD) services	641	1%
Use only long-term services and supports (LTSS)	25,296	57%
Use LTSS and MH services	7,985	18%
Use DD and either MH or LTSS	1,675	4%
Use AOD and either MH or LTSS	2,494	6%
Other high-risk/high-cost beneficiaries	4,284	10%
Total individuals who are high-risk, high-cost Medicare-Medicaid enrollees of all ages in the entire State	44,608	100%[1]
Total DD service users[2]	2,608	6%
Total MH service users[2]	12,390	28%
Total AOD users[2]	3,191	7%
Total LTSS users[2]	35,411	79%

SFY = State fiscal year, July 1 through June 30.

NOTE: This table presents data for the entire State, including beneficiaries residing in the State's two counties that are not participating in the MFFS demonstration. The actual number of beneficiaries eligible for the demonstration is lower because of exclusions determined after these analyses.

[1] Percentages do not total exactly 100% because of rounding.

[2] These four rows include enrollees using multiple services, so the total exceeds 100%.

SOURCE: Washington Department of Social & Health Services and Washington State Health Care Authority: HealthPathWashington: A Medicare and Medicaid Integration Project for Washington State. Appendix F, p. 48. 2012.

As shown in ***Table 4***, the total Medicare and Medicaid FFS spending on all Medicare-Medicaid enrollees in the State was $2.6 billion in calendar year 2007. The largest components of Medicare spending were Part D drug coverage, 28 percent; inpatient hospital, 26 percent; outpatient hospital, 13 percent; physician services, 9 percent; and 8 percent for skilled nursing facilities. Most Medicaid expenditures for Medicare-Medicaid enrollees were for LTSS: 56 percent of expenditures on community-based LTSS, 34 percent for institutional LTSS, and 10 percent for all other Medicaid services.

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

Population	Medicaid expenditures	Medicare expenditures	Total expenditures
Medicare and Medicaid enrollees statewide	$1.3 billion	$1.3 billion	$2.6 billion

CY = calendar year.

NOTE: Publicly available data on expenditures for Medicare-Medicaid enrollees do not reflect the State's MFFS demonstration eligibility criteria. The figures in this table include expenditures for all Medicare-Medicaid enrollees in the State, including residents in the two counties that are not included in the MFFS demonstration.

SOURCE: Centers for Medicare & Medicaid Services: Medicare-Medicaid Enrollee State Profile: Washington, n.d. http://www.integratedcareresourcecenter.com/PDFs/StateProfileWA.pdf. As obtained on March 20, 2013.

2.3 Relevant Historical and Current Context

History/Experience with Coordinated Care. Washington has more than a decade of experience with managing chronic conditions in FFS Medicaid (Washington proposal, 2012, pp. 3, 7–8, 20). From 2002 to 2006, Washington contracted with the King County Area Agency on Aging and a consortium of community agencies to provide disease management services to Aged, Blind, and Disabled (ABD) Medicaid beneficiaries across the State (Center for Health Care Strategies, 2008). The State also has a long history of delivering publicly financed health care services through capitated managed care.

In 2007, Washington replaced the disease management program with the Chronic Care Management (CCM) program, and its experience with that program guided the design of the MFFS demonstration. Eligibility for CCM was based on a score of 1.5 from the PRISM predictive modeling system. The State contracted for services from area agencies on aging that worked with individuals to provide them a medical home and taught individuals self-management skills. All services, including behavioral health, chemical dependency, and LTSS, were coordinated. CCM served a limited number of beneficiaries. Preliminary research on the CCM, cited in the State's MFFS demonstration proposal, indicated that the program had the potential for achieving improved outcomes and cost savings (Washington proposal, 2012, pp. 71–72). The CCM program ended when the State's MFFS demonstration was implemented in 2013 (Washington State Health Care Authority, 2013c and 2013d).

Other Initiatives. Washington has a long history of efforts to rebalance its LTSS; 80 percent of Medicaid beneficiaries receive LTSS in home and community settings, and there is an emphasis on choice of providers as well as setting. An AARP report in 2011 ranked Washington as second in the nation for overall performance of its LTSS system (Washington proposal, 2012, p. 3).

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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 Washington managed fee-for-service (MFFS) demonstration:

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

3.2 Approach

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

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

3.3 Monitoring Implementation of the MFFS Demonstration by Key Demonstration Design Features

The major design features of the Washington MFFS demonstration are described using a common framework that RTI will apply to all of the demonstrations under the Financial Alignment Initiative as follows:

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

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

Table 5
Demonstration design features and key components

Design feature	Key components
Core components of integrated delivery systems (how the delivery system is organized/integrated; interrelationships among the core delivery system components)	• Health homes • Primary care • LTSS • Behavioral health services • Developmental disability services • Integration functions that bridge delivery systems and roles of community-based organizations
Integrated delivery systems supports	• Health IT applied throughout the demonstration, including use of PRISM at State and provider level • Integration of Medicare and Medicaid data • Data (Medicare claims or encounter data[1]) and other feedback to health homes and other providers (by the State or other entities)

(continued)

Table 5 (continued)
Demonstration design features and key components

Design feature	Key components
Care coordination/case management (by subpopulation and/or for special services) ● Medical/primary ● LTSS ● Behavioral health services ● Integration of care coordination	● Assessment process ● Service planning process ● Care management targeting process ● Support of care transitions across settings ● Communication and hand-offs between care coordinators/case managers and providers
Benefits and services	● Scope of services/benefits ● New or enhanced services ● Excluded services ● Service authorization process
Enrollment and access to care	● Provider accessibility standards ● Marketing/education protocols ● Enrollment brokers ● Beneficiary information and options counseling ● Opt out, disenrollment, and auto-assignment policy ● Enrollment in health homes ● Phased enrollment of eligible populations ● Workforce development for worker supply and new functions
Beneficiary engagement and protections	● Policies to integrate Medicare and Medicaid grievances and appeals ● Quality management systems ● Ongoing methods for engaging beneficiary organizations in policy decisions and implementation ● Approaches to capture beneficiary experience, such as surveys and focus groups
Demonstration financing model and methods of payment to health homes and providers	● Financing model—managed fee for service ● Health homes to which the State is directly making payments ● Innovative payment methods to providers
Elements of payments to health homes	● Tiered payment structure

IT = information technology; LTSS = long-term services and supports; PRISM = Predictive Risk Intelligence System.

[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 impact 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.

3.4 Implementation Tracking Elements

Through document review and interviews with State agency staff, we will identify and describe the delivery system for Medicare-Medicaid enrollees in the eligible population. This will enable us to identify key elements that Washington intends to modify through the MFFS

demonstration and measure the effects of those changes. Using a combination of case study methods, including document review, and telephone interviews, we will conduct a descriptive analysis of the key Washington MFFS demonstration features.

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

During site-visit interviews and our ongoing communication with the State, we will collect detailed information on how Washington has structured care coordination for beneficiaries enrolled in the MFFS demonstration. We will identify the roles and functions of health homes in coordinating primary care and other medical services, their linkages with LTSS and behavioral health services, and their rationale for adopting this delivery system. We will also assess what has changed in the provision of care coordination under the MFFS demonstration.

We will also collect data from the State to track implementation through the State Data Reporting System (SDRS). The State will submit quarterly MFFS demonstration statistics and qualitative updates through the SDRS (described in ***Section 3.5, Progress Indicators***, and 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 MFFS demonstration director as needed to understand Washington's entries. We will make additional calls to State agency staff and key informants as needed to keep abreast of MFFS demonstration developments. We will use site-visit interviews to learn more about what factors are facilitating or impeding progress or leading to revisions in the Washington MFFS demonstration implementation.

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

Table 6
Implementation tracking elements by demonstration design feature

Design feature	Tracking elements
Integrated delivery system	● Contracts with health homes ● Documentation of coordination activities between health homes and care coordination organizations ● New waiver authorities submitted for the demonstration and approved by CMS ● Emergence of new health homes ● Strategies for integrating primary care, behavioral health, and LTSS (as documented in State policies, contracts, or guidelines) ● Recognition and payment for care/services by nontraditional workers ● Innovative care delivery approaches adopted by the demonstration ● Systems developed for avoiding duplication ● Provider agreements with health homes
Integrated delivery system supports	● Integration of Medicare and Medicaid data ● Ongoing learning collaboratives of primary care providers ● Support with dissemination and implementation of evidence-based practice guidelines (e.g., webinars for providers; topics addressed in learning collaboratives) ● Decision-support tools provided or supported by State (e.g., practice-level reporting on QIs) ● State efforts to build health home and provider core competencies for serving beneficiaries with various types of disabilities ● Provision of regular feedback to health homes and providers on the results of their performance measures
Care coordination	● Adoption of person-centered care coordination practices ● State systems for collecting data on care coordination use ● As available, care coordination activities directed to individual enrollees ● Requirements for assessment and service planning ● Requirements for coordination and integration of clinical, LTSS, and behavioral health services ● Approaches to stratify care coordination intensity based on individual needs ● Requirements for care transition support, medication reconciliation, notification of hospitalizations ● State actions to facilitate adoption of EMR and EHR ● Use of informatics to identify high-risk beneficiaries
Benefits and services	● Phase-in of new or enhanced benefits and methods to communicate them to enrollees and potential enrollees ● Adoption of evidence-based practices and services (e.g., use of chronic disease self-management programs, fall prevention programs, other)

(continued)

Table 6 (continued)
Tracking elements by demonstration design feature

Design feature	Tracking elements
Enrollment and access to care	• State efforts to provide integrated consumer information on enrollment, benefits, choice of health home providers • Options counseling and information provided by Aging and Disability Resource Centers and State Health Insurance Assistance Programs • Initiatives to increase enrollment in the demonstration • Strategies for expanding beneficiary access to demonstration benefits • Emergence of new worker categories/functions (e.g., health coaches, community care workers)
Beneficiary engagement and protections	• Strategies implemented to engage beneficiaries in oversight of the demonstration • Quality management strategy, roles, and responsibilities • Implementation of quality metrics • Adoption of new policies for beneficiary grievances and appeals based on demonstration experience • Role of the ombudsman program
Financing and payment	• Revisions to the demonstration's initial payment methodology • Risk-mitigation strategies • Performance incentive approaches • Value-based purchasing strategies

EHR = electronic health records; EMR = electronic medical records; LTSS = long-term services and supports; QI = quality improvement.

3.5 Progress Indicators

In addition to tracking implementation of demonstration design features, we will also track progress indicators, including growth in health home enrollment and disenrollment patterns, based on Washington MFFS demonstration data. These progress indicators will be reported quarterly by Washington through the SDRS, which will be the RTI evaluation team's tool for collecting and storing information and for generating standardized tables and graphs for quarterly monitoring reports for CMS and the State. The primary goals of the system are to serve as a repository for up-to-date information about the Washington MFFS demonstration design and progress, to capture data elements on a quarterly basis, and to monitor and report on demonstration progress by individual States and the demonstrations as a whole. More detail on the SDRS can be found in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

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

Table 7
Examples of progress indicators

Indicator
Eligibility
No. of beneficiaries eligible to participate in the demonstration
Enrollment
Total no. of beneficiaries currently enrolled in the demonstration care model
No. of beneficiaries newly enrolled in the demonstration care model as of the end of the given month
No. of beneficiaries automatically (passively) enrolled in the demonstration care model
Disenrollment
No. of beneficiaries who opted out of the demonstration care model prior to enrollment
No. of beneficiaries who voluntarily disenrolled from the demonstration care model
No. of beneficiaries whose enrollment in the demonstration care model ended involuntarily (e.g., died, moved out of area, lost Medicaid eligibility, were incarcerated)
Demonstration service area
Whether the demonstration is currently statewide vs. in specific counties or geographic areas and provide list if in specific geographic areas
Specific to demonstrations that use health homes
No. of health homes currently participating in the demonstration care model
No. of enrollees receiving health home services currently participating in the demonstration care model

3.6 Data Sources

The evaluation team will use a variety of data sources to assess whether the Washington MFFS demonstration was implemented as planned; identify modifications made to the design features during implementation; document changes in the time frame or phase-in of key elements; and determine factors that facilitated implementation or presented challenges. These data sources include the following:

- **State policies and State requirements for health home provider agreements:** The evaluation team will review a wide range of State-developed documents that specify Washington's approach to implementing its MFFS demonstration in order to develop a baseline profile of its current delivery system. Review of Washington's agreements with CMS articulated through the demonstration Memorandum of Understanding (MOU, 2012), Final Demonstration Agreement (Agreement, 2013), waivers, contracts, and State Plan Amendments will further enhance our understanding of Washington's approach.

- **Demonstration data (collected via the State Data Reporting System):** On a quarterly basis, we will collect data from Washington to inform ongoing analysis and feedback to the State and CMS throughout the MFFS demonstration. Specifically, we will collect data to track policy and operational changes and progress indicators that are mostly numeric counts of key demonstration elements presented in ***Table 7***. These demonstration data also may include specific information provided by CMS or other

entities engaged in this demonstration, and incorporated into the State Data Reporting System.

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

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

  – Members of the demonstration advisory council
  – Governor's Health Policy Advisor
  – State officials, such as:
    - Secretary of the Department of Social and Health Services
    - State of Washington Medicaid Director
    - Assistant Secretary, Aging and Long-Term Support Administration
    - Assistant Secretaries of Behavioral Health and Service Integration, Developmental Disabilities Administration, and Aging and Long Term-Support
    - Assistant Secretary of Developmental Disabilities Administration
    - MFFS demonstration project director
    - HCA, Health Home program director
    - State staff responsible for eligibility and enrollment policy, quality management, provider support, care coordination policy, data and research
  – Health Home Lead Entity director
  – Care Coordination Organization director
  – Area Agency on Aging
  – Regional Service Networks
  – Other providers
  – CMS staff

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

3.7 Analytic Methods

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

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4. Impact and Outcomes

4.1 Beneficiary Experience

4.1.1 Overview and Purpose

The evaluation will assess the impact of the Washington managed fee-for-service (MFFS) demonstration on beneficiary experience. Using mixed methods (i.e., qualitative and quantitative approaches), we will monitor and evaluate the experience of beneficiaries, their families, and caregivers. Our methods will include the following:

- the beneficiary voice through focus groups and stakeholder interviews conducted by RTI;
- results of surveys that may be conducted by Washington, CMS, or other entities;
- Washington MFFS demonstration data and data from other sources submitted via the State Data Reporting System (SDRS; e.g., data on eligibility, loss of eligibility, stakeholder engagement activities);
- claims and encounter[5] data obtained from CMS to analyze utilization as well as access to services and outcomes for key quality measures; and
- interviews with Washington MFFS demonstration staff during site visits or telephone interviews with RTI.

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

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

[5] 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 impact 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.

Through beneficiary focus groups and key stakeholder interviews (i.e., consumer and advocacy group members), we also will explore whether we can identify specific MFFS demonstration features in Washington that may influence replication in other States. We will also collect information from State demonstration staff and CMS or other entities that reflects the beneficiaries' experiences (e.g., grievances and appeals, disenrollment patterns), using RTI's State Data Reporting System. ***Section 3, Demonstration Implementation Evaluation***, describes topics we will monitor and document through interviews with Washington MFFS demonstration staff and document reviews, including consumer protections and other demonstration design features intended to enhance the beneficiary experience. Refer to ***Section 4.2*** for a discussion of the use of claims and encounter data to establish baseline information about the beneficiaries eligible for the MFFS demonstration, and how we will use these data to inform our understanding of the impact of the Washington MFFS demonstration on access to care and health outcomes.

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

- What impact does the Washington MFFS demonstration have on the beneficiary experience overall and for beneficiary subgroups?
- What factors influence the beneficiary health home enrollment decision?
- Do beneficiaries perceive improvements in their ability to find needed health services?
- Do beneficiaries perceive improvements in their choice of care options, including self-direction?
- Do beneficiaries perceive improvements in how care is delivered?
- Do beneficiaries perceive improvements in their personal health outcomes?
- Do beneficiaries perceive improvements in their quality of life?

4.1.2 Approach

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

Our framework for evaluating beneficiary experience is influenced by work conducted by the Center for Health Care Strategies (CHCS), which identified the essential elements of

integration affecting beneficiary experience, including the care process and quality of life (Lind and Gore, 2010). Its work is intended to guide the design of integrated care systems for Medicare-Medicaid enrollees and to do so in ways that strengthen the beneficiary experience in the areas defined in ***Table 8***.

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

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Table 8
Methods for assessing beneficiary experience by beneficiary impact

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	Washington MFFS demonstration data[2]	Interviews with Washington agency staff on MFFS demonstration implementation
Integrated delivery system					
Choice					
Beneficiaries have choice of medical, behavioral, and LTSS *services*.	X	X	X	X	X
Beneficiaries have choice of medical, behavioral, and LTSS *providers*.	X	X	X	X	X
Beneficiaries have choice to self-direct their care.	X	X	—	X	X
Beneficiaries are empowered and supported to make informed decisions.	X	X	—	—	—
Provider network					
Beneficiaries report that providers are available to meet routine and specialized needs.	X	X	X	X	—
Beneficiaries report that LTSS and behavioral health are integrated into primary and specialty care delivery.	X	X	—	X	—
Beneficiary engagement					
Beneficiaries consistently and meaningfully have the option to participate in decisions relevant to their care.	X	X	X	X	—
There are ongoing opportunities for beneficiaries to be engaged in decisions about the design and implementation of the demonstration.	X	X	—	—	X

(continued)

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

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	Washington MFFS demonstration data[2]	Interviews with Washington agency staff on MFFS demonstration implementation
Streamlined processes					
Beneficiaries can easily navigate the delivery system.	X	X	—	X	—
Reduced duplication of services					
Beneficiary burden is reduced through elimination of duplicative tests and procedures.	—	X	—	X	—
Enrollment and access to care					
Enrollment					
Beneficiaries have choices and assistance in understanding their enrollment options.	X	X	—	X	X
Beneficiaries report ease of disenrollment.	X	X	—	X	—
Rate of disenrollment from the demonstration by reason.	—	—	—	X	—
Rate of disenrollment from the demonstration by reason.	—	—	—	X	—
Access to care					
Beneficiaries can access the full range of scheduled and urgent medical care, behavioral health services, and LTSS.	X	X	—	X	—
Beneficiaries report improved quality of life due to access to full range of services.	X	X	X	—	—
Beneficiaries report that waiting times for routine and urgent primary and specialty care are reasonable.	X	X	—	X	—

(continued)

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

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	Washington MFFS demonstration data[2]	Interviews with Washington agency staff on MFFS demonstration implementation
Health Outcomes					
Beneficiary health rating.	—	—	X	—	—
Quality of Life					
Days free from pain.	—	—	X	—	—
Beneficiaries get the social and emotional supports they need.	—	X	X	—	—
Beneficiaries report that they are satisfied with their life.	—	X	X	—	—
Cultural appropriateness					
Beneficiaries have access to multilingual and culturally sensitive providers.	X	X	—	X	X
Beneficiaries report that written and oral communications are easy to understand.	X	X	—	X	—
Delivery systems supports					
Data sharing and communication					
Information is available and used by beneficiaries to inform decisions.	X	X	—	—	X
Beneficiaries report that providers are knowledgeable about them and their care history.	X	X	—	X	—
Beneficiaries have adequate discharge and referral instructions.	X	X	—	X	X

(continued)

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

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	Washington MFFS demonstration data[2]	Interviews with Washington agency staff on MFFS demonstration implementation
Beneficiaries report that providers follow up after visits or discharge.	X	X	—	X	—
Beneficiaries understand their options to specify that personal health data not be shared.	X	X	—	X	—
Care coordination					
Assessment of need					
Assessment process integrates/addresses health, behavioral health, and LTSS.	X	X	—	X	X
Medical providers actively participate in individual care planning.	—	X	X	—	—
Beneficiaries report active participation in the assessment process.	X	X	—	X	—
Person-centered care					
Care is planned and delivered in a manner reflecting a beneficiary's unique strengths, challenges, goals, and preferences.	X	X	—	X	—
Beneficiaries report that care managers have the skills and qualifications to meet their needs.	—	X	X	—	—
Beneficiaries report that providers listen attentively and are responsive to their concerns.	X	X	X	X	—
Coordination of care					
The system facilitates timely and appropriate referrals and transitions within and across services and settings.	X	X	X	X	—

(continued)

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

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	Washington MFFS demonstration data[2]	Interviews with Washington agency staff on MFFS demonstration implementation
Beneficiaries have supports and resources to assist them in accessing care and self-management.	X	X	—	X	—
Beneficiary reports ease of transitions across providers and settings.	X	X	X	X	—
Family and caregiver involvement					
Beneficiaries have the option to include family and/or caregivers in care planning.	X	X	—	X	—
The family or caregiver's skills, abilities, and comfort with involvement are taken into account in care planning and delivery.	X	X	—	X	—
Benefits and services					
Awareness of covered benefits					
Beneficiaries are aware of covered benefits.	X	X	—	X	—
Availability of enhanced benefits					
The demonstration covers important services to improve care outcomes that are not otherwise available through Medicaid or Medicare program.	—	—	—	X	X
Flexible benefits are available to meet the needs of beneficiaries.	—	—	—	X	X
Awareness of enhanced benefits					
Beneficiaries are aware of enhanced benefits and use them.	X	X	—	X	—

(continued)

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

Direct measure	Key stakeholder interviews	Beneficiary focus groups	Recommended survey question[1]	Washington MFFS demonstration data[2]	Interviews with Washington agency staff on MFFS demonstration implementation
Beneficiary safeguards					
Beneficiary protections					
Beneficiaries understand their rights.	X	X	—	X	—
Beneficiaries are treated fairly, are informed of their choices, and have a strong and respected voice in decisions about their care and support services.	X	X	—	X	—
Complaints, grievances, and appeals					
Beneficiaries have easy access to fair, timely, and responsive processes when problems occur.	X	X	—	X	—
Number and type of beneficiary complaints, grievance, and appeals.	—	—	—	X	—
Advocacy/member services					
Beneficiaries get assistance in exercising their rights and protections.	X	X	—	X	—
Finance and payment					
Provider incentives					
Beneficiary experience is taken into account when awarding provider incentives.	X	—	—	—	X

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

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

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

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

Table 9 highlights some of the quantitative measures of beneficiary experience we will monitor and evaluate using MFFS demonstration statistics and claims or health home 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 impact of the Washington MFFS demonstration on beneficiary outcomes, including for subpopulations. The draft focus group protocol and the draft stakeholder interview protocol are both discussed in this section and are available in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

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

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

Rate of auto-enrollment to health homes (if available)
Rate of disenrollment from health homes, by reason[1]
Rate of beneficiaries who opt out of enrolling into health homes
Number and type of beneficiary complaints, grievance, and appeals
Use of preventive services[1]
Nursing facility admissions and readmissions[1]
Emergency room use[1]
Hospital admission and readmission rates[1]
Follow-up care after hospital discharge[1]

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

4.1.3 Data Sources

We will rely on five major data sources to assess beneficiary experience as shown in ***Table 8***. In this section, we describe our plan for using focus group and stakeholder interviews; results of beneficiary surveys planned by the State, CMS, or other entities; the State MFFS demonstration data entered into the State Data Reporting System; and interviews with State MFFS demonstration staff.

4.1.3.1 Focus Groups

We will conduct four focus groups in Washington to gain insight into how the MFFS demonstration affects beneficiaries. To ensure that we capture the direct experience and observations of those served by the Washington MFFS demonstration, focus groups will be limited to MFFS demonstration enrollees, their family members, and informal caregivers. ***Table 10*** shows our current plan for the composition and number of focus groups.

We are aware that Washington has conducted its own focus groups during the planning/ design phase of the MFFS demonstration. We will use findings from the State's activities to inform the content of our focus groups. Preliminary topics of the focus groups include beneficiaries' understanding of the MFFS demonstration, rights, options, and choices (e.g., primary care provider); their benefits; concerns or problems encountered; experience with care coordination; and access to primary and specialty care, and LTSS. We will conduct focus groups no sooner than 1 year after implementation so that beneficiaries have had a substantial amount of experience with the demonstration. We will make the decision regarding timing and content of the focus groups in conjunction with CMS.

Table 10
Purpose and scope of State focus groups

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

LTSS = long-term services and supports; MFFS = managed fee for service.

We will recruit focus group participants from eligibility and enrollment files independent of input from the State. In doing so, we will identify beneficiaries reflecting a range of eligibility, clinical, and demographic characteristics enrolled in the Washington MFFS demonstration. Our subcontractor, the Henne Group, will use a structured approach for screening potential participants and obtaining their agreement to participate. If there appear to be high rates of individuals who are enrolled in a health home but have not developed a health action plan, we will consider convening focus groups of these enrollees to understand why they have chosen not to engage. We will work closely with Washington MFFS demonstration staff to make the process of recruiting focus group members as smooth as possible for beneficiaries, such as selecting an accessible site and ensuring transportation and any needed special accommodations and supports to allow for full participation. Focus group recruitment and all focus group arrangements will be conducted with an awareness of the subpopulations of concern in Washington. We will investigate the prevalence of non-English–speaking beneficiaries in the eligible population, and determine whether to hold any of the focus groups in languages other

than English. A preliminary focus group protocol is presented in the *Aggregate Evaluation Plan* (Walsh et al., 2013). The protocol will be modified based on final decisions about focus group composition, content, and our understanding of issues raised during implementation of the Washington MFFS demonstration.

4.1.3.2 Key Stakeholder Interviews

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

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

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

Table 11
Preliminary subpopulations and scope of key stakeholder interviews

Primary purpose	**Baseline:** Assess understanding of and satisfaction with MFFS demonstration design; expectations for the MFFS demonstration; perceived concerns and opportunities. **Throughout demonstration:** Spot improvements and issues as they emerge and assess factors facilitating and impeding positive beneficiary experience. **Final year:** Assess extent to which expectations were met; major successes and challenges; lessons learned from beneficiary's perspective.
Subpopulations	Interviews will be held with consumer and advocacy groups whose members are served by the Washington MFFS demonstration. These may include the following: ● Advocacy and consumer organizations representing the MFFS demonstration's eligible populations ● Advocacy and consumer organizations participating in the HealthPathWashington Advisory Team ● Beneficiaries serving on the HealthPathWashington Advisory Team
Number and frequency	**Baseline**: Up to eight telephone interviews within the first year of MFFS demonstration implementation. **Throughout demonstration**: Up to eight telephone or in-person interviews in Washington each year to be conducted with the same individuals each time, unless other stakeholders or topics of interest are identified. **Final year**: Up to eight telephone or in-person interviews.

MFFS = managed fee for service.

4.1.3.3 Beneficiary Surveys

The RTI evaluation team will not directly administer any beneficiary surveys as part of the evaluation, and we are not requiring that States administer beneficiary surveys for purposes of the evaluation. We will include in the evaluation relevant findings from beneficiary surveys that may be conducted for this demonstration by Washington, CMS, or other entities. We will recommend standard questions for inclusion in Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys across all demonstrations under the Financial Alignment Initiative, such as quality of life measures. We will participate in discussions with the State and CMS (and other CMS contractors, as appropriate) regarding content and sampling issues. Topics on which we will recommend common questions across State demonstrations are shown in ***Table 8***. We understand that in addition to the CAHPS survey that will be administered for all MFFS demonstrations, the State is considering administering another beneficiary survey for the Washington MFFS demonstration.

4.1.3.4 Demonstration Data

We will use data about the MFFS demonstration that we collect from Washington during site visits, from reports and other materials developed by the State, through the State Data Reporting System, and data obtained from CMS or other entities to assess the beneficiary experience. Data of particular interest include the following:

- Complaint, appeal, and grievance data from CMS or other entities, as available.
- Rates of disenrollment from health homes.
- Information about waiting lists or lags in accessing services, which will provide useful indications of where the system lacks capacity as a topic for discussion during site visits or focus groups.

The above quantitative indirect measures will be collected for all Medicare-Medicaid enrollees served under the MFFS demonstration, and will be analyzed by subpopulations.

In addition, Washington plans to monitor quality using State-specific process and MFFS demonstration measures (CMS and State of Washington, 2012, p. 56). To the extent relevant, we will use findings from these State-specific metrics to augment our assessment of beneficiary experience and outcomes in the Washington MFFS demonstration.

4.1.3.5 Interviews with Washington MFFS Demonstration Staff

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

4.1.4 Analytic Methods

Our analysis will assess beneficiary experience and determine, where possible, how it is affected by financial model and MFFS demonstration design features. We also want to examine

whether and how beneficiary experience varies by subpopulations. The Henne Group will audio-record all focus groups, subject to approval of the group members, and the audio-recordings will be transcribed. Key stakeholder interview and focus group transcripts will be imported and analyzed using QSR NVivo 9, qualitative data analysis software, to identify emergent themes and patterns regarding beneficiary experiences during the MFFS demonstration and issues related to the evaluation research questions. A structured approach to qualitative analysis in NVivo 9 will allow us to identify themes by subpopulations within and across States. Because it is implementing a managed fee-for-service demonstration, we are particularly interested in comparing Washington's findings with those of MFFS model demonstrations in other States, and in determining whether particular design features in the Washington MFFS demonstration are likely to affect beneficiary experience.

Most MFFS demonstration data will be collected and tracked through the State Data Reporting System. We will also request summary statistics and reports from Washington on its beneficiary experience surveys. Information from site visits and site-reported data beyond those described specifically in this section also are expected to inform analysis of beneficiary experience research questions. The findings will be grouped into the beneficiary experience domains defined in ***Section 4.1.2***.

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

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

4.2.1 Purpose

This section of the report outlines the research design, data sources, analytic methods, and key outcome variables (quality, utilization, and cost measures) on which we will focus in evaluating the Washington managed fee-for-service (MFFS) demonstration. These analyses will be conducted using secondary data including Medicare and Medicaid claims and managed care encounter data.[6] This section addresses the following research questions:

- What impact does the Washington MFFS demonstration have on utilization patterns in acute, long-term, and behavioral health services, overall and for beneficiary subgroups?

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

[6] Encounter data from Medicare Advantage (MA) or Program of All-Inclusive Care for the Elderly (PACE) plans in the predemonstration-period are needed to evaluate demonstration impact 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.

- Does the Washington MFFS demonstration change access to medical, mental health, chemical dependency, long-term services and supports (LTSS) overall and for beneficiary subgroups? If so, how?

- What impact does the Washington MFFS demonstration have on cost and is there evidence of cost savings? How long did it take to observe cost savings? How were these savings achieved?

In this section, we discuss our approach to identifying the eligible population for the Washington MFFS demonstration and for identifying comparison group beneficiaries. This section also describes the data sources, key analyses to be performed over the course of the demonstration, and the quality measures that will inform the evaluation. RTI will use both descriptive and multivariate analyses to evaluate the Washington MFFS demonstration. Results of descriptive analyses focusing on differences across years and important subgroups on key outcome variables will be included in the Washington MFFS quarterly reports to CMS and the State, and annual reports. Multivariate analyses of each year of demonstration data and over the course of the demonstration, controlling for beneficiary characteristics will be included in the final evaluation.

Savings will be calculated annually for the Washington MFFS demonstration using an actuarial approach. The impact of the demonstration on costs will also be calculated using a multivariate regression-based approach for the final evaluation report; this calculation will include Medicaid, Medicare Parts A and B, and Medicare Part D costs, as well as any performance payment made to the State as part of the demonstration.

4.2.2 Approach

An appropriate research design for the evaluation must consider whether selection is a risk for bias. Several potential sources of selection bias exist in the Washington MFFS demonstration.

The State determines eligibility for automatic enrollment into a health home, but beneficiaries may choose to opt out or disenroll. The reasons for opting out or disenrolling after being enrolled will vary but may be related to demonstration benefits. Beneficiaries not eligible for alignment with the demonstration, such as those already enrolled in a Medicare Advantage plan or Program of All Inclusive Care for the Elderly (PACE), can become eligible for the demonstration if they disenroll from their current plans or programs. In addition to the potential for selection bias at enrollment, there is also potential for selection bias among those who enroll because engagement with a health home is voluntary. Therefore, not all beneficiaries will receive the services available to them, and the intensity of services received will vary.

To limit selection bias in the evaluation of this demonstration, we will use an intent-to-treat design. This design will address potential selection issues by including the entire population of beneficiaries eligible for the Washington MFFS demonstration based on their designations as high-cost high-risk individuals. Under the intent-to-treat framework, outcome analyses will include all beneficiaries eligible for the demonstration, including those who opt out of automatic enrollment into a health home, those who enroll but then later disenroll, and those who enroll but

do not receive health home services. The outcomes for this group will be compared with outcomes for a comparison group of individuals with similar characteristics. This approach diminishes the potential for selection bias and highlights the effect of the demonstration on all beneficiaries in the demonstration-eligible population. In addition, RTI will compare the characteristics of several subsets of beneficiaries eligible for the demonstration. These include those receiving health home services, those enrolled in a health home but not receiving services, and those who are eligible but choose not to be enrolled, acknowledging that interpreting such results will be difficult given likely selection bias.

4.2.2.1 Identifying Demonstration Group Members

The demonstration group for Washington MFFS includes full-benefit Medicare-Medicaid enrollees who are eligible for Medicaid State Plan health home services. To analyze quality, utilization, and costs in the predemonstration period, and throughout the demonstration period, Washington 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 enrollees eligible for or enrolled in the demonstration (***Table 12***). The file, constructed after the end of each quarter, will list all demonstration-eligible Medicare-Medicaid enrollees who were eligible for enrollment in a health home in the quarter, with additional variables indicating whether they were actually enrolled in each month. Eligible individuals who were not enrolled in a health home in a given month will still be part of the evaluation under the intent-to-treat research design. This file will also contain personal identifying information for linking to Medicare and Medicaid data.

Table 12
State demonstration evaluation (finder) file data fields

Data field	Length	Format	Valid value	Description
Medicare Beneficiary Claim Account Number (Health Insurance Claim Number [HICN])	11	CHAR	Alphanumeric	The HICN. Any Railroad Retirement Board (RRB) numbers should be converted to the HICN number prior to submission to the MDM.
MSIS number	20	CHAR	Alphanumeric	MSIS identification number.
Social security number (SSN)	9	CHAR	Numeric	Individual's SSN.
Sex	1	CHAR	Alphanumeric	Sex of beneficiary (1=male or 2=female).
Person first name	30	CHAR	Alphanumeric	The first name or given name of the beneficiary.
Person last name	40	CHAR	Alphanumeric	The last name or surname of the beneficiary.
Person birth date	8	CHAR	CCYYMMDD	The date of birth (DOB) of the beneficiary.
Person ZIP code	9	CHAR	Numeric	9-digit ZIP code.
Monthly eligibility identification flag	1	CHAR	Numeric	Coded 0 if identified as not eligible for the demonstration, 1 if identified as eligible from administrative data, 2 if identified as eligible from nonadministrative data.

(continued)

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

Data field	Length	Format	Valid value	Description
Monthly enrollment indicator	1	CHAR	Numeric	Each monthly enrollment flag variable would be coded 1 if enrolled, and zero if not. Quarterly demonstration evaluation (finder) files would have 3 such data fields
Monthly health home service receipt indicator	1	CHAR	Numeric	Coded 0 if a person did not receive a health home service during the month, and coded 1 if received a health home service during the month

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

4.2.2.2 Identifying a Comparison Group

The methodology described in this section reflects the plan for identifying comparison groups based on discussions between RTI and CMS and detailed in the *Aggregate Evaluation Plan* (Walsh et al., 2013). Identifying the comparison group members will entail two steps: (1) selecting the geographic area from which the comparison group will be drawn and (2) identifying the individuals who will be included in the comparison group.

Because Washington intends to implement either a capitated or MFFS demonstration in all areas of the State, we will consider a comparison group from out-of-State Metropolitan Statistical Areas (MSAs). In general, we expect to draw out-of-State comparison groups from multiple comparison States and areas. However, if for any reason the Washington MFFS demonstration is implemented in a smaller area of the State, we will determine whether there are areas within Washington that could also be part of the comparison group. The approach for identifying in-State comparison areas would be the same as the process for identifying an out-of-State comparison group, described below.

We will use statistical distance analysis to identify potential comparison areas that are most similar to the Washington capitated demonstration counties in regard to costs, care delivery arrangements, policy affecting Medicare-Medicaid enrollees, population density, and the supply of medical resources. The specific measures for the statistical distance analysis we will use are Medicare spending per Medicare-Medicaid enrollee, Medicaid spending per Medicare-Medicaid enrollee, nursing facility users per 65-and-over Medicaid beneficiary, HCBS users per 65-and-over Medicaid beneficiary, Personal Care users per 65-and-over Medicaid beneficiary, Medicare Advantage, Medicaid managed care penetration for full-benefit Medicare-Medicaid enrollees, Medicaid-to-Medicare physician fee ratios, population per square mile, and patient care physicians per thousand population. The three LTSS variables capture how areas differ in the settings in which they provide these services. Variation in LTSS policy is most easily visible in the population using the most LTSS (i.e., those aged 65 and over). The relative importance of institutional care observed in that population is expected to affect such use in the population under age 65 as well.

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

4.2.2.3 Issues/Challenges in Identifying Comparison Groups

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

1. **Similarities between demonstration and comparison groups:** Comparison group members should be as much like demonstration group members as possible and sufficient data are needed to identify and control for differences between the comparison group members and the demonstration group members.

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

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

4. **Medicaid data:** Significant time delays currently exist in obtaining Medicaid data. If unaddressed, this could result in delays in formulating appropriate comparison groups. Timeliness of MSIS data submissions will need to be considered if out-of-State comparison areas are required for the evaluation.

4.2.2.4 Propensity Score Framework for Identifying Comparison Group Members

Because comparison group members may differ from the demonstration group on individual characteristics, we will compute propensity scores for the demonstration and comparison group members. The propensity score represents how well a combination of characteristics, or covariates, predicts that a beneficiary is in the demonstration group. To compute these scores for beneficiaries in the demonstration and comparison groups, we will first identify beneficiary-level and market-level characteristics to serve as covariates in the propensity-score model. Beneficiary-level characteristics may include demographics, socioeconomic, health, and disability status, and county-level characteristics may include health

care market and local economic characteristics. Once the scores are computed, we will remove from the comparison group any beneficiaries with a propensity score lower than the lowest score found in the demonstration group to ensure that the comparison group is similar to the demonstration group.

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

4.2.3 Data Sources

Table 13 provides an overview of the data sources to be used in the Washington MFFS evaluation of quality, utilization, and cost. Data sources include Medicare and Medicaid fee-for-service data, Medicare Advantage encounter data, and health home claims and encounter data.[7] These data will be used to examine quality, utilization, and cost in the predemonstration period and during the demonstration. Data will be needed for all beneficiaries enrolled in a health home as well as other beneficiaries in the eligible population who are not enrolled. Note that data requirements for individual beneficiaries will depend on whether they were in Medicare fee-for-service or Medicare Advantage in the pre- and postdemonstration periods.

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

The activities to identify demonstration and comparison groups and to collect and utilize 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.

[7] Health home lead entities will submit at most one fee-for-service claim per month, depending on the number and type of encounters between care coordinators and beneficiaries that month. The State requires the health home lead entities to submit encounter level data (i.e., indicators of the number and type of each care coordination activity) to the State. If these are included as part of the State's MSIS (or t-MSIS) submission, we will incorporate encounters with other claims. If not, we may need to pursue access to care coordination encounters from the State.

Table 13
Data sources to be used in the Washington MFFS demonstration evaluation analyses of quality, utilization, and cost

Aspect	Medicare fee-for-service data	Medicaid fee-for-service data	Encounter data[1]
Obtained from	CMS	CMS	CMS
Description and uses of data	Will be pulled from ● Part A (hospitalizations) ● Part B (medical services) Will be used to evaluate quality of care, utilization, and cost during the demonstration. These data will also be used for beneficiaries who disenroll from health homes, or never enroll; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration, and for comparison groups that may be in-State and/or out-of State.	Medicaid claims and enrollment data will include data on patient characteristics, beneficiary utilization, and cost of services. Eligibility files will be used to examine changes in number and composition of Medicare-Medicaid enrollees. Will also need these data for beneficiaries who disenroll from health homes, or never enroll; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration, and for comparison groups.	Pre- and post-period beneficiary encounter data (including Medicare Advantage, and health home, 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 disenroll from health homes, or never enroll; for predemonstration analyses of demonstration-eligible beneficiaries for the 2 years prior to the demonstration; and for comparison groups that may be in-State and/or out-of State.
Sources of data	Will be pulled from the following: ● NCH Standard Analytic File ● NCH TAP Files ● Medicare enrollment data	Will be pulled from the following: ● MSIS (file on inpatient care, institutional, and the "other" file) ● Medicaid eligibility files	Data will be collected from the following: ● CMS ● Medicare enrollment data

(continued)

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

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

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

[1] Encounter data from Medicare Advantage (MA) or Program of All-Inclusive Care for the Elderly (PACE) plans in the pre-period are needed to evaluate demonstration impact 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 (HIPAA) of 1996. CMS, however, makes data available for certain research purposes provided that specified criteria are met. RTI has obtained the necessary Data Use Agreement (DUA) with CMS to use CMS data. A listing of required documentation for requesting CMS identifiable data files such as Medicare and MSIS is provided at http://www.resdac.umn.edu/medicare/requesting_data.asp.

4.3 Analyses

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

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

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

3. multivariate difference-in-differences analyses of quality, utilization, and cost measures using an out-of State comparison group; and

4. comparisons of characteristics and outcomes between selected subgroups of eligible beneficiaries.

RTI will calculate savings annually for the Washington MFFS demonstration using an actuarial approach. More information on the actuarial approach is provided in the Final Demonstration Agreement (Agreement, 2013). The results of these annual savings calculations will be used by CMS (or another contractor) in calculating any performance payments from CMS to the State under the MFFS financial alignment model. RTI will also calculate the demonstration's impact on costs, using a multivariate regression-based approach for the final evaluation report.

The approach to each of the four analyses is outlined below in ***Table 14***, and more detail is provided in the *Aggregate Evaluation Plan* (Walsh et al., 2013). Note that the Washington MFFS demonstration was not implemented as of the first date of a calendar year. Therefore, the first annual report will cover the first complete calendar year plus any months of implementation prior to the first calendar year. The activities for the analyses may be revised if modifications are made to the demonstrations or if data sources are not available as anticipated. If modifications to this evaluation plan are required, they will be documented in the annual and final evaluation reports as appropriate.

Table 14
Quantitative analyses to be performed for Washington MFFS demonstration

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

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

4.3.1 Monitoring Analysis

Data from Medicare FFS, MSIS files, or other data provided by Washington via the State Data Reporting System will be analyzed quarterly to calculate means, counts, and proportions on selected quality, utilization, and cost measures common across States, depending on data availability. Examples of measures that may be included in these quarterly reports to CMS include rates of inpatient admissions, emergency room visits, long-term nursing facility admissions, cost per member per month, and all-cause hospital readmission and mortality. We will present the current value for each quarter and the predemonstration period value for each outcome and will look at trends as well.

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

4.3.2 Descriptive Analysis on Quality, Utilization, and Cost Measures

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

To perform this analysis, we will develop separate (unlinked) Medicare, and Medicaid beneficiary-level analytic files annually to measure quality, utilization, and cost. Though the Medicare and Medicaid 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 period. Because

of the longer expected time lags in the availability of Medicaid data, Medicare fee-for-service data will be available sooner than Medicaid fee-for-service data, including health home encounter data. Therefore, we expect that the first annual report will include predemonstration Medicare and Medicaid fee-for-service data and Medicare fee-for-service—as well as Medicare Advantage, if they are available— data for the demonstration period. Medicaid fee-for-service data including health home encounter data will be incorporated into later reports as the data become available each year.

Consistent with the intent-to-treat approach, all individuals eligible for the demonstration will be included in the analysis, regardless of whether they opt out of automatic enrollment into a health home or disenroll from a health home. Data will be developed for a 2-year predemonstration period, and for each of the years of the demonstration for the demonstration group and comparison group. Note that the predemonstration period data will include beneficiaries who would have been eligible for the demonstration in the predemonstration period. For those beneficiaries with shorter periods of demonstration eligibility, because of beneficiary death or change of residence, for example, the analysis will weight their experience by months of eligibility within a performance period.

We will measure predemonstration and annual utilization rates and costs of Medicare- and Medicaid-covered services together, where appropriate, to look at trends in the type and level of service use during the demonstration. We will calculate average use rates and costs at predemonstration and for each demonstration period. Use rates will be stratified by hierarchical condition category (HCC) scores, which are derived from models predicting annual Medicare spending based on claim-based diagnoses in a prior year of claims where higher scores are predictive of higher spending, health status measures, or similar measures. We will adjust for hospitalizations in the prior year using categorical HCC scores or similar measures. Chi-square and t-tests will be used to test for significant differences in use across years and between subpopulations, such as Medicare-Medicaid enrollees using behavioral health services and those referred for long-term care services. The Washington MFFS demonstration has a case management system that can track encounters related to LTSS, and health home care coordination will also be tracked as a new service being delivered under the MFFS demonstration. The availability of case management and care coordination data will allow the RTI team to conduct analyses of patterns of case management and care coordination service use.

4.3.3 Multivariate Analyses of Quality, Utilization, and Cost Measures

In the final year of the evaluation, we will use data collected for the eligible population in Washington MFFS demonstration and data for the selected comparison group that will have been adjusted using propensity-score weighting methods to analyze the effect of the demonstration using a difference-in-differences method. This method uses both pre- and post-period data for both the demonstration and comparison groups to estimate effects. This method will be applied to these data for each quality, utilization, and cost outcome described in the next section for the final evaluation. The analytic approaches are described in greater detail in the *Aggregate Evaluation Plan* (Walsh et al., 2013).

4.3.4 Subpopulation Analyses

For subpopulations of focus in the Washington MFFS demonstration, we will evaluate the impact of the demonstration on quality, utilization, and access to care for medical, LTSS, and mental health and chemical dependency services, and also examine qualitative data gathered through interviews, focus groups, and surveys. RTI will compare the characteristics of beneficiaries who enroll in health homes and actively participate (receive health home services regularly) with those of beneficiaries who enroll but do not receive health home services and those who are eligible but do not enroll, and will conduct analyses to further explore demonstration effects on enrollees, acknowledging that selection bias must be taken into account in interpreting the results. Descriptive analyses for annual reports will present results on selected measures stratified by subpopulations (e.g., those using and not using health home services, behavioral health services, LTSS). Multivariate analyses performed for the final evaluation will account for differential effects for subpopulations in specification testing by using dummy variables for each of the specific subpopulations of interest one at a time so that the analyses can suggest whether quality, utilization, and cost are higher or lower for each of these groups.

Because engagement in the health home model is voluntary, not all eligible beneficiaries will receive the services available to them. Thus, one set of subgroup analyses will compare the characteristics and key outcomes of eligible beneficiaries who receive different levels of health home services, ranging from no use to intensive use. We will also divide groups based on the amount of time enrolled in a health home. The definitions of these levels will be made once distributions of intensity of use become clear. These analyses may include both univariate and multivariate methods.

4.4 Utilization and Access to Care

Medicare and Medicaid data will be used to evaluate changes in the levels and types of services used, ranging along a continuum from institutional care to care provided at home (***Table 15***). In addition to the services shown in ***Table 15***, the Washington MFFS analysis will include a specific focus on receipt of health home services. Because participation in health homes is voluntary, the receipt of health home services is an important measure. A stated requirement of health home providers is the performance of a comprehensive in-person health screening and completion of a Health Action Plan within 90 days of a beneficiary's expressing interest in receiving health home services. The analyses will include the rate of performance of the screenings on new health home enrollees to the extent that these data are reported in a standardized way through MSIS or other available data source. Note that ***Table 15*** indicates the sources of data for these analyses during the demonstration, given that these analyses will include beneficiaries enrolled in the demonstration as well as those who are part of the population eligible for the demonstration, but do not enroll. Because Medicaid health home services are a key part of the demonstration, we will examine the individual and market factors associated with the use of these services.

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

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

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

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

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

4.5 Quality of Care

Across all States RTI will evaluate a core quality measure set for monitoring and evaluation purposes. There are multiple data sources for quality measures: claims and encounter data, which RTI will obtain from CMS and analyze for evaluation measures listed in ***Table 16***; and information collected by Washington, CMS, or others and provided in aggregate to the RTI team for inclusion in reports. CMS and Washington have identified a set of quality measures that will help to determine the amount of any retrospective performance payments. The quality measures for the Washington MFFS demonstration, listed in the Washington Final Demonstration Agreement (Agreement, 2013), include some measures noted in this report, as well as additional measures. RTI expects to have access to the aggregated results of these additional measures and will include them in the evaluation as feasible and appropriate, understanding that these data are not available for the predemonstration period or for the comparison group.

RTI and CMS have developed the core set of evaluation measures for use across State demonstrations; the evaluation will also include a few measures specific to the Washington MFFS demonstration.

Table 16 provides a working list of the core quality measures to be included in the evaluation of the Washington MFFS demonstration. The table specifies the measure, the source of data for the measure, whether the measure is intended to produce impact estimates, as well as a more detailed definition and specification of the numerator and denominator for the measure. RTI may identify additional evaluation measures appropriate to the Washington MFFS

demonstration to supplement the measures in ***Table 16***. We will finalize any State-specific quality measures that RTI may identify for the evaluation within the first year of implementation and will obtain the needed data from CMS or other sources; these measures will not require any additional State reporting.

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

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

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

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

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

(continued)

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

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

(continued)

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

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

(continued)

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

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

(continued)

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

Measure concept (specific measure)	Data sources and responsibility for data collection	Domain (prevention, care coordination, beneficiary experience)	Will evaluation produce impact estimates?[1]	Definition (link to documentation if available)	Numerator/denominator description
Treatment of alcohol and substance use disorders Initiation and Engagement of Alcohol and Other Drug Dependent Treatment	Claims/encounter RTI will acquire and analyze	Care coordination	Yes	The percentage of demonstration-eligible Medicare-Medicaid enrollees with a new episode of alcohol or other drug (AOD) dependence who received the following: a. Initiation of AOD Treatment. The percentage who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. b. Engagement of AOD Treatment. The percentage who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. (http://www.qualityforum.org/QPS/)	Numerator: Among demonstration-eligible Medicare-Medicaid enrollees (a) Initiation: AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis; (b) Engagement: AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted. Do not count engagement encounters that include detoxification codes (including inpatient detoxification) Denominator: Demonstration-eligible Medicare-Medicaid enrollees age 13 years and older who were diagnosed with a new episode of alcohol and drug dependency during the intake period of January 1–November 15 of the measurement year. EXCLUSIONS: Exclude those who had a claim/encounter with a diagnosis of AOD during the 60 days before the IESD. For an inpatient IESD, use the admission date to determine the Negative Diagnosis History. For an ED visit that results in an inpatient stay, use the ED date of service.
Depression screening and follow-up Screening for clinical depression and follow-up	Claims/encounter RTI will acquire and analyze	Prevention, care coordination	Yes	Percentage of patients aged 18 and older screened for clinical depression using an age-appropriate standardized tool AND follow-up plan documented (http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/2014_eCQM_EP_June2013.zip).	Numerator: Demonstration-eligible Medicare-Medicaid enrollees whose screening for clinical depression using an age-appropriate standardized tool AND follow-up plan is documented. Denominator: All demonstration-eligible Medicare-Medicaid enrollees 18 years and older with certain exceptions (see source for the list).

ACSC = ambulatory care sensitive conditions; AMI = acute myocardial infarction; CABG = coronary artery bypass graft; CHF = congestive heart failure; COPD =chronic obstructive pulmonary disease; CR = cardiac rehabilitation/secondary prevention; CVA = cerebrovascular accident; ED = emergency department; IESD = index episode start date; MDS = minimum data set; PCI = percutaneous coronary intervention; UTI = urinary tract infection.

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

NOTE: Definitions, use, and specifications are as of May 13, 2014.

4.6 Cost

To determine annual total costs (overall and by payer), we will aggregate the Medicare and Medicaid payments and the costs for the population eligible for the demonstration, including those who are eligible but not enrolled, per the intent to treat evaluation design. This approach will help us to detect overall cost impact and remove potential bias that may result from self-selection of beneficiaries who enroll in health homes. We will include Part D per member per month (PMPM) and any PMPM reconciliation data provided by CMS in the final assessment of cost impact to ensure that all data are available. Any retrospective performance payments to the State will also be included in the final impact analysis.

The evaluation will analyze cost data for the service types shown in Table 14 in the previous section on utilization with the addition of prescription drug costs. As with quality and utilization analyses, the descriptive and impact analyses presented in the annual report will include a comparison group. We will present results for important subgroups, and in more detail so as to better understand their demonstration experience. We will also create a high-cost-user category and track costs of this group over time. To do this, we will measure the percentage of beneficiaries defined as high cost in the first Demonstration Period (e.g., those beneficiaries in the top 10 percent of costs) to determine a threshold. In subsequent years, we will look at the percentage of beneficiaries above the selected threshold to learn more about potential success in managing the costs of high-cost beneficiaries as a result of the demonstration.

4.7 Savings Calculations

The Washington MFFS demonstration will be eligible for performance payments from CMS based on achieving statistically significant Medicare savings, as determined by annual actuarial calculations. The savings calculations, separately performed by RTI, will reflect Medicare savings net of increased Federal Medicaid spending. The methodology for the savings calculations is described in the Washington MFFS MOU (MOU, 2012) and Final Demonstration Agreement (Agreement, 2013). The results of the RTI savings calculations will be used by CMS or another contractor to determine whether the State is eligible for a performance payment and if so, the amount of that payment. The impact of the demonstration on costs will be calculated using a multivariate regression-based approach for the final evaluation report; this calculation will include Medicaid, Medicare Parts A and B, and Medicare Part D costs, as well as any performance payment made to the State as part of the demonstration.

4.8 Analytic Challenges

Obtaining Medicaid fee-for-service data for the predemonstration and demonstration periods and health home services data for the demonstration period will be critical for the evaluation. The Medicaid data are necessary to measure quality, utilization, and costs. The health home services data are necessary to fully measure care coordination and level of engagement in the demonstration. It will be important for Washington to submit Medicaid fee-for-service data in a timely manner. It will also be important for CMS to continue to work with other States that may include comparison group populations to update and maintain their MSIS/t-MSIS submissions. Because the timing and availability of health home services data are not yet known,

RTI will continue to work closely with CMS to understand how these data can best be utilized by the evaluation. Other analytic challenges will include addressing financing issues including upper payment limit (UPL) issues, provider taxes, and disproportionate share hospital (DSH) payments as well as possible state policy changes over the course of the demonstration. RTI will work closely with CMS and the State to understand these issues and to monitor changes over the course of the demonstration and will develop approaches to incorporate these issues into analyses as necessary.

5. References

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