DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

State Demonstrations Group

JUL 0 3 2018

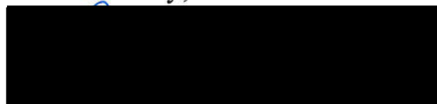
Donna Frescatore
Director
Office of Health Insurance Programs
New York State Department of Health
Empire State Plaza
Corning Tower (OCP – 1211)
Albany, NY 12237

Dear Ms. Frescatore:

The Centers for Medicare & Medicaid Services (CMS) has completed its review of the comprehensive evaluation design for New York's section 1115(a) demonstration (Project No. 11-W-00304/0), titled "Medicaid Redesign Team" (MRT). We have determined that the submission dated June 22, 2018 meets the requirements set forth in the Special Terms and Conditions and, therefore, hereby approve the MRT's evaluation design.

If you have any questions, please do not hesitate to contact your project officer, Mr. Adam Goldman. Mr. Goldman can be reached at (410) 786-2242, or at Adam.Goldman@cms.hhs.gov.

Sincerely,



Angela D. Garner
Director
Division of System Reform Demonstrations

Enclosure

cc: Michael Melendez, Associate Regional Administrator, CMS New York Region
Nicole McKnight, Program Branch Manager, CMS New York Region
Maria Tabakov, State Lead, CMS New York Region

New York Medicaid Redesign Team Section 1115 Demonstration
Evaluation Plan Framework

Start Date of Demonstration Period: November 30, 2016
End Date of Demonstration Period: March 31, 2021

OVERVIEW

In compliance with the Special Terms and Conditions (STCs) set forth under New York State's Medicaid Redesign Team (MRT) section 1115 demonstration agreement (the Demonstration), the New York State Department of Health (NYSDOH) will develop a plan for ongoing comprehensive evaluation of the effectiveness of the Demonstration in achieving the stated goals for improving access to health care for the Medicaid population, improving the quality of health services delivered, and expanding coverage with resources generated through managed care efficiencies to additional low- income New Yorkers. The Demonstration includes several key activities including enrollment of new populations, quality improvement, and coverage expansions. The evaluation plan assesses the degree to which the goals of the Demonstration have been achieved and/or activities of the Demonstration have been implemented. The plan is in adherence with the evaluation standards set forth in Section XI (2) and in and in 42 CFR 431.424.

The evaluation plan focuses on the following domains of the Demonstration:

- Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports
- Managed Long Term Care (MLTC)
- Medicaid Managed Care (MMMC) / Temporary Assistance to Needy Families (TANF)

In evaluating the Demonstration, the effectiveness of the Express Lanes Eligibility and Twelve-Month Continuous Eligibility Period programs within MMMC/TANF will also be investigated.

The evaluation of Delivery System Reform Incentive Program (DSRIP), Health and Recovery Plans (HARP), and the Self- Direction Pilot will be conducted separately.

A draft of this evaluation was made available for public comment from December 20, 2016 to January 10, 2017 on the NYSDOH website. No comments were received.

TECHNICAL APPROACH

Within each domain, major Demonstration goals and objectives were identified. The specific questions to be addressed by the evaluation were based on the following criteria:

1. Potential for measurement, including (where possible and relevant) baseline measures that can help to isolate the effects of Demonstration initiatives and activities over time;
2. Potential for improvement, consistent with the key goals of the Demonstration; and
3. Potential to coordinate with the NYSDOH's ongoing performance evaluation and monitoring efforts.

To the extent possible, the evaluation plan incorporated all design evaluation questions outlined by CMS in Attachment O of the STC's. The state has sought approval from CMS to omit from the evaluation plan any questions that do not align with these criteria.

Once research questions were selected to address the Demonstration's major program goals and activities, hypotheses were generated and study designs developed. Specific variables and measures were then identified to correspond to each research question, and a process was developed for identifying data sources that are most appropriate and efficient in answering each of the evaluation questions. Data sources to be used in the evaluation include:

Medicaid Data Warehouse
This robust dataset includes enrollment and eligibility data as well as claims and managed care encounters. Several 3M products are used to evaluate members' clinical risk (Clinical Risk Groups) and preventable event measures, such as Prevention Quality Indicators. These data will be used to evaluate patterns of care for the sub-populations of interest.

Minimum Data Set (MDS 3.0)
MDS 3.0 is a federally required standardized assessment and the basis of the comprehensive assessment for all residents of long-term care facilities. NY will use this data to calculate the member's time in a nursing facility prior to discharge to the community.

MLTC Satisfaction data
In 2007, the NYSDOH, in consultation with the MLTC plans, developed a satisfaction survey of MLTC enrollees. The survey was field tested and is now administered by the NYSDOH's external quality review organization, IPRO. New York State sponsors the biennial MTLC satisfaction survey. The survey contains three sections: health plan satisfaction; satisfaction with select providers and services, including timeliness of care and access; and self-reported demographic information.

Money Follows the Person (MFP) data
In January 2007, the federal Centers of Medicare and Medicaid Services (CMS) approved New York´s application to participate in the Money Follows the Person Rebalancing Demonstration Program. The MFP Demonstration, authorized under the Deficit Reduction Act and extended through the Affordable Care Act, involves transitioning eligible individuals from long-term institutions like nursing facilities and intermediate care facilities into qualified community-based settings. The cohort for this evaluation will be defined by participation in the MFP program and the MFP tracking system will be used.

New York State of Health (NYSoH) Enrollment
Since the inception of the Affordable Care Act, Medicaid enrollees who are not eligible for cash assistance enroll through the NYSoH rather than through local Departments of Social Services (LDSS). These data enrollment data will be used, in addition to enrollment data from the LDSS, to obtain a complete picture of Medicaid enrollees.

Uniform Assessment System-NY (UAS-NY) Community Health data
The MLTC plans are required to collect and report to the NYSDOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then semi-annually thereafter. The UAS-NY is an electronic system

based on a uniform data set, which standardizes and automates needs assessments for home and community based programs in New York. The UAS-NY is based on the interRAI suite of assessment instruments. interRAI is a collaborative network of researchers in over 30 countries committed to improving health care for persons who are elderly, frail, or disabled. With the UAS-NY, functional status data demonstrates its importance to inform eligibility for the MLTC program, provide the basis for the MLTC plans' care management planning processes, and facilitate a plan's identification of areas where the patient's status differs from optimal health or functional status. Assessment data are submitted by plans to the UAS-NY electronically as assessments are conducted, and are added to the database upon submission. The UAS-NY submissions are stored as two static assessment files. One containing the most recent assessment for enrollees in each plan from January through June. The second containing the most recent assessment for enrollees in each plan from July through December. These two files will be used to describe and evaluate the MLTC plan performance.

Statewide Planning and Research Cooperative System (SPARCS)
SPARCS is an all-payer hospital database in New York State. UAS-NY records that matched to SPARCS and had a SPARCS primary diagnosis of respiratory infection, urinary tract infection, congestive heart failure, anemia, sepsis or electrolyte imbalance were included in the numerator for the PAH measure.

All data sources are readily available to the NYSDOH staff and will be made available to the selected Independent Evaluator upon request. For those data sources not housed on intranet network drives (i.e. Medicaid Warehouse and NYSoH Enrollment data), Contractor evaluation staff will be granted user rights to access the systems for this evaluation. Because the periodicity of data refresh varies across sources/systems, the most recently available data cycles may be inconsistent and adjustments will be made to ensure evaluation periods are consistent and thoroughly explained.

The final evaluation plan for each domain, and details regarding each evaluation study design, including data collection plans, statistical methods for measuring effects, and level of analysis, are outlined below.

Each component of the comprehensive evaluation was designed with consideration for the scientific rigor of the analysis, how the analysis will support the determination of cost effectiveness, and how the activities and reporting will be maintained. While the Demonstration seeks to generate cost savings and promote quality care, observed changes may be attributed to not only the Demonstration itself, but also external factors, including other State- or national-level policy initiatives and overall market changes and trends. For each Demonstration activity, a conceptual framework was developed depicting how specific Demonstration goals, tasks, activities, and outcomes are causally connected to serve as the basis for the evaluation methodology. Chosen methods aim to account for any known or possible external influences described above and their potential interactions with the Demonstration's goals and activities.

ANALYSIS PLAN

When available, credible contextual information will be gathered in attempt to isolate the Demonstration's contribution to any observed effects as well as describe the relative contributions of other factors that may influence the observed effects. This will include documenting any relevant legal,

regulatory, or policy changes or other trends – including the sequence, scope, and duration of such changes – at both a State and national level that are likely to influence the observed outcomes.

Where possible and relevant, the evaluation will incorporate baseline measures, and account for secular trends, for each of the selected variables included in the evaluation. Data for each of the targeted variables and measures will be collected regularly so that changes in outcome measures and variables can be observed on a longitudinal basis. The evaluation will compare rates of performance and measures with State and national benchmarks, where relevant and feasible.
Incorporating benchmark measures will allow for external comparisons of Demonstration measures to State and national trends, further isolating the impacts of the Demonstration by controlling for external factors influencing the observed effects.

The evaluation features described above (analysis of qualitative contextual information, the use of baseline measures, ongoing data collection, and benchmarking) represent quasi-experimental means by which the evaluation team will determine the effects of the Demonstration. Evaluation conclusions will include key findings associated with individual research questions addressed as well as integrated information combining the results of individual evaluation questions to make broad conclusions about the effects of the Demonstration. In addition, the evaluation will include specific recommendations of best practices and lessons learned that can be useful for NYSDOH, other States, and CMS.

EVALUATION ACTIVITIES

Domain 1. Individuals Receiving Long Term Supports and Services

Study population

New York's Medicaid Redesign Team Section 1115 Demonstration contains two components related to LTSS delivery. First, it requires nursing facility residents and individuals in need of more than 120 days of community-based long-term care to enroll in a Managed Long-Term Care (MLTC) plan to receive LTSS as well as other ancillary services. Second, the demonstration allows MLTC-eligible individuals who are discharged from a nursing home or adult home into the community to qualify for enrollment into a MLTC plan using a special income standard. For this evaluation, the second group, the HCBS expansion group, will be considered a subset of the larger population.

1. *Managed Long-Term Care (MLTC)*

   The MLTC plans are required to collect and report to the NYSDOH information on enrollees' levels of functional and cognitive impairment, behaviors, and clinical diagnoses. This information is collected at enrollment and then semi-annually thereafter. From 2005 through September 2013, these data were collected using the Semi-Annual Assessment of Members (SAAM) instrument, a modified version of the Federal (Medicare) Outcome and Assessment Information Set (OASIS-B). The SAAM was used to establish clinical eligibility for the MLTC program and assist health providers in care planning and outcome monitoring.

   Beginning on October 1, 2013, the SAAM instrument was replaced by the Uniform Assessment System – New York (UAS-NY) Community Assessment instrument which may include a Functional Supplement and/or Mental Health Supplement. The UAS-NY is an electronic system based on a uniform data set, which standardizes and automates needs assessments for home

and community based programs in New York. Whether using the SAAM instrument or the UAS-NY, functional status data remain critical to inform eligibility for the MLTC program, provide the basis for the MLTC plans' care management planning processes, and facilitate a plan's identification of areas where the patient's status differs from optimal health or functional status.

Submission of assessment data occurred twice a year with the SAAM instrument. Now assessment data are submitted by plans to the UAS-NY electronically as assessments are conducted, and are added to the database upon submission. Each year, the Department concatenates the MLTC UAS-NY submissions to create two static assessment files. One containing the most recent assessment for enrollees in each plan from January through June. The second containing the most recent assessment for enrollees in each plan from July through December. These two files are used by the Department to describe and evaluate the MLTC plan performance.

Given the change of assessment instrument and mandatory nature of the MLTC program, the evaluator should evaluate post-intervention trends by examining DOH calculated performance metrics overtime. Because NY has two static files from which quality measures are derived, January through June and July through December, rates from both datasets should be utilized by the evaluator in their trend overtime analysis.

The broad goals of the New York Managed Long-Term Care (MLTC) program evaluation are to assess the impact of the Demonstration on: 1) Expand access for Managed Long-Term Care for Medicaid enrollees in need of long-term care services and supports; 2) Stability or Improvement in Patient Safety; 3) Stability or Improvement in Quality of Care; 4) Stability or Reduction in preventable acute hospital admissions; and 5) Stability or Improvement in consumer satisfaction. Toward these goals, the following evaluation questions will be addressed:

Goal 1: To expand access to Managed Long-Term Care for Medicaid enrollees in need of long-term services and supports.

Question: Enrollment into MLTC will continue to grow and then stabilize as the program is mandatory across the State. At what point in the demonstration did the population stabilize in size?

Hypothesis: The MLTC program experienced rapid growth but stabilized over the course of the demonstration.

Methods: Using DOH enrollment numbers, the evaluator will quantitatively assess the growth of the program over the demonstration.

Data Sources:

- Uniform Assessment System-NY (UAS-NY) community Health data

Goal 2: Demonstrate stability or improvement in patient safety

Question 1: Is the percent of the MLTC population having an emergency room visit in the last 90 days since assessment stable or improving over the course of the demonstration?

Question 2: Is the percent of the MLTC population having a fall requiring medical intervention in the last 90 days since assessment stable or improving over the course of the demonstration?

Hypothesis: The MLTC performance on patient safety measures will remained stable or improved over the course of the demonstration.

Methods: Using DOH computed six month rates, the evaluator will qualitatively assess if the percent of the MLTC population having an emergency room visit or a fall requiring medical intervention in the last 90 days since assessment are stable or improving over the course of the demonstration.

Data Sources:

- Uniform Assessment System-NY (UAS-NY) Community Health data

Goal 3: Demonstrate stability or improvement in quality of care

Question 1: Are enrollees perceived timely access to personal, home care and other services such as dental care, optometry and audiology stable over time or improving?

Questions 2: Is the percent of the MLTC population accessing preventive care services such as the flu shot and dental care consistent or improving?

Hypothesis: The MLTC performance on quality of care and satisfaction measures has remained stable or improved over the course of the demonstration

Methods: DOH sponsors a satisfaction survey of the MLTC membership every other year. Using DOH calculated satisfaction rates, the evaluator will qualitatively assess if the percent of the MLTC population are stable or improving in their perceived timeliness to access to services such as dental care, optometry and audiology over the course of the demonstration. The evaluator will also qualitatively assess, using DOH computed six month rates of access, if enrollees are stable or improved on accessing preventative services such as flu shots and dental care.

Data Sources:

- Uniform Assessment System-NY (UAS-NY) community Health data
- MLTC Satisfaction data

Goal 4: To stabilize or reduce preventable acute hospital admissions

Question: Is the MLTC population experiencing stable or reduced rates of potentially avoidable hospitalization?

Hypothesis: Rates of potential avoidable hospitalizations will remain stable or be reduced over the demonstration.

Methods: Using DOH annually calculated rates, the evaluator will qualitatively assess if the rate of potentially avoidable hospitalizations are remaining stable or improving over the demonstration. These results will show the effectiveness of the waiver in reducing avoidable hospitalizations.

Data Sources:

- Uniform Assessment System-NY (UAS-NY) Community Health data
- SPARCS

Goal 5: Demonstrate stability or improvement in consumer satisfaction

Question 1: What is the percent of members who rated their managed long-term care plan within the last six months as good or excellent? And has this percentage remained stable or improved over the demonstration?

Question 2: What is the percent of members who rated the quality of care manager/case manager services within the last six months as good or excellent? And has this percentage remained stable or improved over the demonstration?

Question 3: What is the percent of members who in the last six months rated their home health aide/personal care aide/personal assistant, care manager/case manager, regular visiting nurse or covering/on call nurse services were usually or always on time? And has this percentage remained stable or improved over the demonstration?

Question 4: What is the percent of members who rated the quality of home health aide/personal care aide/personal assistant services within the last six months as good or excellent? And has this percentage remained stable or improved over the demonstration?

Hypothesis: Rates of satisfaction will remain stable or improve over the demonstration.

Methods: DOH sponsors a satisfaction survey of the MLTC membership every other year. Using DOH calculated satisfaction rates, the evaluator will qualitatively assess if the rating of satisfaction with the member's plan, care manager, home health aide, has remained stable or improved over the demonstration.

Data Sources:

- Satisfaction data

2. *Individuals Moved from Institutional Settings to Community Settings for Long-Term Services and Supports*

The broad goals of New York's Home and Community based services expansion (HCBS) program are to assess the impact of the Demonstration on: 1) Improve Access to MTLC for those that transitioned from an institutional setting to the community; 2) Stability or Improvement in Patient Safety; 3) Stability or Improvement in Quality of Care. Toward these goals, the following evaluation questions will be addressed:

Goal 1: Improve Access to MTLC for those that transitioned from an institutional setting to the community

Question 1: For those who transition from an institutional setting to the community, did the percent enrolling in MLTC increase over the demonstration?

Hypothesis: The percent of institutional discharges to the community enrolling in MLTC will increase over the course of the demonstration.

Methods: Using DOH calculated rates, the evaluator will quantitatively assess the growth of the transition population over the demonstration.

Data Sources:

- Uniform Assessment System-NY (UAS-NY) Community Health data
- Money Follows the Person (MFP) data
- Minimum Data Set (MDS 3.0)

Goal 2: Stability or Improvement in Patient Safety

Question 1: Is the percent of the HCBS Expansion population having an emergency room visit in the last 90 days since assessment stable or improving over the course of the demonstration?

Question 2: Is the percent of the HCBS Expansion population having a fall requiring medical intervention in the last 90 days since assessment stable or improving over the course of the demonstration?

Hypothesis: The performance on these patient safety measures for the HCBS Expansion population will remain stable or improved over the course of the demonstration

Methods: Using DOH computed six-month rates, the evaluator will qualitatively assess if the percent of the HCBS Expansion population having an emergency room visit or a fall requiring medical intervention in the last 90 days since assessment is stable or improving over the course of the demonstration.

Data Sources:

- Uniform Assessment System-NY (UAS-NY) Community Health data
- Money Follows the Person (MFP) data

Goal 3: Stability or Improvement in Quality of Care

Question1: For the HCBS Expansion population that entered MLTC after transitioning from an institutional setting, what percent return to the nursing home within a year of discharge, what was their average level of care need and for those that return within a year, how long on average did they reside in the community?

Questions 2: Is the percent of the HCBS Expansion population accessing preventive care services such as the flu shot and dental care consistent or improving?

Hypothesis: For the HCBS Expansion population, performance on these quality of care measures will remain stable or improved over the course of the demonstration

Methods: Using DOH calculated rates stratified by level of care on the UAS assessment, the evaluator will qualitatively assess if the annual HCBS Expansion population rate of remaining in the community remained stable or improved over the course of demonstration. The evaluator will also qualitatively assess, using DOH computed six-month rates, access to preventive care services is stable or improved for the HCBS population.

Data Sources:

- Uniform Assessment System-NY (UAS-NY) Community Health data
- Money Follows the Person (MFP) data
- Minimum Data Set (MDS 3.0)

Domain 2. Mainstream Medicaid Managed Care (MMMC) and Temporary Assistance for Needy Families (TANF)

<u>Goal 1: To increase access to health insurance through Medicaid enrollment</u>

Express Lane-like Eligibility refers to a Medicaid process through which individuals applying for Temporary Assistance (TA) are automatically considered for Medicaid enrollment without having to file a separate application. The underlying rationale is that Medicaid eligibility determination and enrollment can be facilitated given that, in most cases, applicants for TA are also eligible for Medicaid given the lower income threshold for the former. While Express Lane Eligibility does not represent a newly implemented Medicaid enrollment procedure, it's authority under the 1115 Waiver, applied to adults, is a recent change.

Evaluation of the Express Lane-like eligibility initiative will provide feedback to program staff regarding the number and characteristics of Medicaid recipients enrolled through this mechanism, providing insights into how effectively the program reaches potential recipients in terms of both number and characteristics. Information gained could potentially be used to enroll potential recipient groups who may be underrepresented in this enrollment mechanism.

Given the program objective of increasing access to health insurance through Medicaid by streamlining the application and enrollment process, the following questions would be addressed in the evaluation:

Question 1: How many recipients are enrolled through Express Lane-like eligibility?
Question 2: Are there differences in the demographic and clinical characteristics of Medicaid beneficiaries enrolled through Express Lane-like Eligibility as compared to those not enrolled through this mechanism?
Question 3: What portion of the beneficiaries enrolled through express lane-like eligibility were later deemed to be ineligible for coverage?

Hypotheses:

1. The number of recipients enrolled through this mechanism will remain steady through the waiver period.
2. Differences in demographic and clinical characteristics of Medicaid beneficiaries should be similar in patterns seen for other types of Medicaid aid category.
3. Because the eligibility levels for receiving TA are lower than for Medicaid only, it is unlikely that many beneficiaries will be retroactively ineligible.

Methods:

While Express Lane-like eligibility is not a new Medicaid enrollment procedure, there has not been a mechanism available within the Medicaid enrollment system to identify if recipients were enrolled with this procedure. Tracking of the number of recipients enrolled into Medicaid under the Express Lane-like initiative will be begin as soon as possible after November 30, 2016, the start date of Medicaid Redesign Team section 1115 demonstration when an identifier will be created for all new enrollment records. The number and percentage of recipients enrolled

through the Express Lane-like eligibility mechanism will be determined monthly and annually over the duration of the Demonstration.

Medicaid claims and enrollment data will be used to compare recipients enrolled through the Express Lane-like mechanism to those enrollees who did not, on demographic and clinical factors. A list of enrollees through this mechanism over a selected two-year period during the Demonstration will be used to identify those individuals in the database. It is anticipated that a two-year period will be a sufficient time frame to identify enough enrollees to allow comparisons to be made. From the claims and enrollment data, demographic (age, sex, race/ethnicity, New York State region) and clinical information (presence or absence of chronic diseases, such as mental illness and diabetes, maternal/delivery, etc.) will be extracted, with comparisons to be made between Express Lane-like enrollment vs. non-Express Lane-like using analytic procedures such as chi-square analysis.

Data Sources:
- Medicaid Data Warehouse
- NYSoH Enrollment Files

Goal 2: To limit gaps in Medicaid eligibility due to fluctuations in recipient income – Twelve -Month Continuous Eligibility Period Initiative

The Twelve-Month Continuous Eligibility initiative, initiated in 2014 with the Affordable Care Act Marketplace, is to prevent lapses in Medicaid coverage due to fluctuations in recipient income, and applies to Medicaid recipients eligible under Modified Adjusted Gross Income (MAGI) guidelines. MAGI eligibility groups include the following:
- Pregnant women;
- Infants and children under the age of 19;
- Childless adults who are: not pregnant, age 19-64, not on Medicare, or could be certified as disabled but not on Medicare;
- Parents/Caretaker relatives;
- Family Planning Benefit Program; and,
- Children in foster care.

MAGI recipients remain eligible for Medicaid until renewal after a 12-month period, during which time recipients are not required to report changes in income, and such changes are not considered even if they are reported by the recipient. Changes in eligibility would be made only in the cases of death, moving out of state, or voluntary disenrollment in Medicaid.

Evaluation of the Twelve-Month Continuous Eligibility for MAGI Individuals program is to provide information to program managers on how effectively continuous enrollment is being implemented, the potential health care benefits associated with 12-month continuous eligibility, as well as possible effects on health care costs. Such information could potentially be used to make program modifications toward increasing effectiveness in preventing lapses in coverage, and/or to ensure greater inclusion of subgroups that may be underserved with this initiative, and to encourage use of preventive services resulting from increased Medicaid coverage to prevent more severe disease and, in turn, prevent potentially higher costs.

The broad goal of the Twelve-Month Continuous Eligibility initiative is to limit gaps in Medicaid coverage due to fluctuations in recipient income. Toward this goal, the following questions will be addressed:

Question1: What is the distribution of enrollees within select continuous enrollment categories, i.e., 12 months, 24 months etc.?
Question 2: Does the continuous enrollment differ by demographic or clinical characteristics?
Question 3: Did Medicaid's average months of continuous enrollment increase following the implementation of continuous eligibility as compared to pre-implementation?
Question 4: Was there an increase in the percentage of Medicaid beneficiaries continuously enrolled for 12 months following implementation of continuous eligibility as compared to pre-implementation?
Question 5: How do outpatient, inpatient and emergency department visits compare pre- and post-implementation of this policy? How have costs been impacted because of the change in utilization?
Question 6: How many of the beneficiaries covered under continuous eligibility would have been ineligible for coverage if not for the waiver?

Hypotheses:

1. Given the mechanism of 12-month continuous eligibility to prevent lapses in Medicaid coverage, months of enrollment per member will show an increase over the five years following the implementation of 12-month continuous eligibility as compared to the five years preceding its implementation. Similarly, the number of enrollees with 12 months continuous enrollment will show an increase over the five years preceding implementation.
2. The use of primary care and other preventive services will increase following the implementation of 12-monthy continuous eligibility. This is expected due to the anticipated continuity of coverage resulting from the initiative.
3. Health care costs for primary care and selected preventive care services will increase following the implementation of 12-month continuous eligibility, given the expected increase in utilization of these services.
4. Total cost of care per recipient will decrease following the implementation of 12-month continuous eligibility. This result is expected because fewer lapses in coverage should occur in the NYS Medicaid population, making preventive care more accessible and thus preventing a more severe illness that is costlier to treat.

Methods:
MAGI Medicaid enrollees will be identified, based on aid category codes, in the enrollment data from January 1, 2014 through December 1, 2018. Medicaid enrollment history for these recipients will be used to determine the number and proportion of recipients who had at least one 12-month period of continuous enrollment during this period.

To understand the characteristics of MAGI recipients that receive 12-month enrollment, those with 12-month enrollment over the 5-year period will be compared to MAGI recipients not showing 12-month enrollment in their enrollment histories. Demographic variables on which comparison will be made include sex, race, and age. Additionally, the presence or absence of chronic diseases will be compared between these two groups as of recipients' first month of

enrollment Medicaid occurring on or after January 1, 2014. Comparisons will be made, using chi-square analysis, on the presence or absence of conditions such as HIV/AIDS, diabetes, serious mental illness, asthma, cardiovascular disease and kidney disease. Clinical Risk Group (CRG) categories and/or diagnosis codes on claims will be used to determine the presence of these conditions.

Medicaid enrollment data will be used to determine months of enrollment per recipient. This will be determined for each of the five years prior to implementation of 12-month continuous eligibility (January 1, 2011 – December 1, 2013) and each of the five years following implementation (January 1, 2014 – December 1, 2018).

An interrupted time series design[1] is proposed to test hypotheses assessing the effect of the 12-month continuous eligibility initiative on Medicaid enrollment. This is a quasi-experimental design in which summary measures of the outcome variable (annual months of enrollment per member, in this case) are taken at equal time intervals over a period prior to program implementation, followed by a series of measurements at the same intervals over a period following program implementation. This design was chosen in consideration of the fact that a control group is unlikely to be available, limiting the ability to separate the effects of this initiative from other statewide health care reform initiatives that are ongoing (e.g., DSRIP, the Affordable Care Act). Given the limitation resulting from the likely absence of a comparison group, this design is advantageous in that potential confounders (i.e., other health care reform initiatives) are minimized in that they would have to occur contemporaneously with the introduction of 12-month continuous eligibility to exert a confounding effect, which is unlikely, but is recognized as possible nonetheless. This design also has the advantage of accounting for secular trends in the enrollment months per member, to which other health care reform initiatives may contribute.

Segmented regression[2] will be used as the primary analytic strategy in the analysis of data under the interrupted time series design in testing hypotheses. This analysis enables the evaluation of changes in the level and trend in the outcome variable, while controlling, as necessary, for such biases as secular trend, serial autocorrelation, and seasonal fluctuation in the outcome variable. A potential issue to address over the study period is change in characteristics of the Medicaid population over time. This could occur through increased enrollment of younger and healthier people into Medicaid, and/or increased movement of older and sicker people from Medicaid fee-for-service to managed care, either of which could confound the effects of the 12-month continuous eligibility initiative on member months of Medicaid enrollment. This will be addressed through adjustment of the outcome variable by standardizing on factors such as age, sex, and health status (e.g., Clinical Risk Grouping[3], Charlson Comorbidity Index[4]), or inclusion of population-level measures of these variables as covariates in the model. Additionally, stratification will be used to assess differential program effects on months of Medicaid enrollment by recipient subgroups (e.g., sex, race, age, NYS region, mental health status). Results will be stratified by demographic and clinical recipient subgroups to assess differential program effects.

To test the hypothesis that that the percentage of recipients continuously enrolled for 12 months will increase in the years following the implementation of this initiative, the dependent variable will be the proportion of enrollees continuously enrolled over a 12-month period, in

each of the five years prior to implementation of 12-month continuous eligibility, and the five years after.

Again, potential confounding due to changes in the Medicaid population will be controlled through standardizing the outcome variable on factors such as age, sex, and health status, or inclusion of such variables in the model, with stratification on various recipient subgroups to assess differential program effects.

The interrupted time series design will also be used to evaluate cost and utilization of primary and preventive care before and after program implementation. To control for the effect of year to year fluctuation in Medicaid enrollment on service utilization and cost, per member per year rates will be computed as the dependent variable in each analysis, for each of the five years prior to, and five years after, the start of the 12-month continuous eligibility initiative.

Medicaid claims data will be used to identify primary care and selected preventive services, including well-care, screening for cancer and management of chronic disease. Costs associated with these services, as well as total care costs, will also be determined from Medicaid claims, to be used in computing the outcome variables for the second and third hypotheses, respectively. To compute per member per year rates for each of these services, the total number of services of each type paid by Medicaid each year will be determined, and divided by the total number of months of enrollment over all recipients for that year and the resulting quotient multiplied by 12. Cost per member per year associated with primary care and preventive services, and for total health care costs, will be computed in the same manner.

Prior to implementation of the 12-Month Continuous Eligibility Initiative, Medicaid enrollees were subject to loss of coverage if their incomes rose above the eligibility threshold. To quantify the number of MAGI enrollees who would have lost coverage using the previous eligibility criteria, Medicaid enrollment staff will maintain a record of reported changes in income received from enrollees. Such records will be used from the inception of the program, if available, or retention of these records will begin as soon as is logistically feasible to do so, and will be maintained on an ongoing basis. Given that Medicaid enrollees are not required to provide information on changes in income until time of eligibility renewal after 12 months, individuals who would otherwise have lost coverage will likely be undercounted.

Data Sources:

- Medicaid data warehouse
- Internal documentation (Medicaid Enrollee Reported Income Changes)
- NYSoH Enrollment Files

EXTERNAL REVIEW / PROCUREMENT OF AN INDEPENDENT EVALUATOR

Table 1. 1115 Demonstration Evaluation Timeline

Time Period	Evaluation Activities
June 2018 – August 2018	Independent Evaluator competitive procurement (RFP) preparation. • **June 2018:** Obtain CMS approval of evaluation framework and confirm funding availability. • **June - July 2018:** Develop RFP including scope of work, major tasks, and contract deliverables. • **August 2018:** Finalize RFP, develop scoring methodology, and obtain necessary approvals.
September 2018 – July 2019	Independent Evaluator RFP process. • **September 2018:** Release RFP and answer questions from potential bidders. • **November 2018:** Receive bids (technical and cost proposals). • **December 2018 – July 2019:** Score submitted proposals, select final contractor, and obtain necessary approvals.
August 2019 – January 2021	Independent Evaluator begins work. Target Dates: • **August 2019 – January 2020**: Contractor orientation, data applications, and other preparatory steps take place. • **January 2020:** Dataset for evaluation period becomes available and can be provided to contractor. Review and analysis begins. Independent Evaluator submits Interim Evaluation Report. • **June 2020:** Draft Interim Evaluation Report submitted to NYSDOH. • **July 2020:** State Public posting of Interim Evaluation Report. • **September 2020**: 1115 Renewal application submitted with Interim Evaluation Report to CMS.

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