DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

State Demonstrations Group

March 25, 2016

Jeffrey A. Meyers
Commissioner
New Hampshire Department of Health and Human Services
Brown Building
128 Pleasant Street
Concord, NH 03301

Dear Mr. Meyers:

The Centers for Medicare & Medicaid Services (CMS) is approving New Hampshire's proposed evaluation design for the section 1115 demonstration entitled, "New Hampshire Health Protection Program (NHHPP) Premium Assistance" (Project Number 11-W-00298/1).

In accordance with the Special Terms and Conditions (STCs), CMS will attach the approved evaluation design as Attachment A and post to our website.

Your project officer, Jessica Woodard, is available to answer any questions concerning your 1115 demonstration or provide technical assistance while implementing the evaluation design. Ms. Woodard can be reached at (410) 786-9249 or Jessica.Woodard@cms.hhs.gov.

Sincerely,

/s/

Andrea J. Casart
Acting Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Richard McGreal, Associate Regional Administrator, CMS Boston Regional Office

2016 NEW HAMPSHIRE HEALTH PROTECTION PROGRAM - *PREMIUM ASSISTANCE PROGRAM* WAIVER (NHHPP PAP)

WAIVER EVALUATION DESIGN PLAN

This program is operated under an 1115 Research and Demonstration Waiver initially approved by the Centers for Medicare & Medicaid Services (CMS) on March 4, 2015.

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Synopsis of New Hampshire Health Protection Program – Premium Assistance Waiver

On March 4, 2015, the New Hampshire Department of Health and Human Services (DHHS) received approval from the Center for Medicare & Medicaid Services (CMS) to develop the New Hampshire Health Protection Program's Premium Assistance Program component as an 1115 Medicaid Demonstration Waiver program. The New Hampshire Health Protection Program (NHHPP) Act includes three components: (1) a mandatory Health Insurance Premium Payment Program (HIPP) for individuals with access to cost-effective employer-sponsored insurance; (2) a bridge program to cover the new adult group in Medicaid managed care plans from August 15, 2014 through December 31, 2015; and (3) a mandatory individual qualified health plan (QHP) premium assistance program (PAP) beginning on January 1, 2016.

In accordance with CMS' waiver requirement, DHHS must develop an evaluation plan for the NHHPP PAP Demonstration waiver no later than 90 days following waiver approval from CMS. The proposed PAP evaluation plan is built on monitoring both process and outcome performance measures that increase in number over the three years potentially available for the waiver due to data varying in collection, processing, and finalization cycles. This increase in available evaluation data over time means that the data available towards the end of 2016 (i.e., first year of the NHHPP PAP) will not be complete and should be considered a first approximation for the first set of monitoring measures, rather than definitive results.

Enrollment activities for the PAP adult population will begin on or before November 1, 2015, depending on whether beneficiaries are enrolled in the Bridge Program. However, regardless of prior enrollment status, Medicaid eligible adults can enroll into health coverage under QHPs and receive premium assistance beginning November 1, 2015, for coverage effective January 1, 2016. This Demonstration will sunset after December 31, 2016 consistent with the current legislative approval for the New Hampshire Health Protection Program pursuant to N.H. RSA 126-A:5, XXIII-XXV, but may continue for up to two additional years, through December 31, 2018, if the New Hampshire legislature authorizes the State to continue the Demonstration and the State provides notice to CMS, as described in the Special Terms and Conditions.[1]

[1] Special Terms and Conditions (STC) Document #11-W-00298/1.

Key Components and Objectives of the QHP PAP

The NHHPP PAP Demonstration will assist the State in its goals to ensure:

1. **Continuity of coverage**—*For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks;*[2]
2. **Plan variety**—*The Demonstration will encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and will encourage QHP carriers to seek Medicaid managed care contracts;*
3. **Cost-effective coverage**—*The premium assistance approach will increase QHP enrollment and result in greater economies of scale and competition among QHPs; and*
4. **Uniform provider access**—*The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire.*

New Hampshire's Demonstration evaluation will include an assessment of the following research hypotheses that address the four goals just described:[3]

1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage.
2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers.
3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs.
4. The Demonstration could lead to an increase in plan variety by encouraging health plans in the Medicaid Care Management Program to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management Program and the Marketplace could afford

[2] The NHHPP PAP Demonstration does not include the medically frail population. Members who self-identify as medically frail will be dropped from the program and enrolled in traditional Medicaid. As such, they will be excluded from the evaluation using appropriate methods but will be counted to report on the frequency of self-declaration.

[3] Reordered from STC #69.1 i-xii to correspond with the content and ordering of four goals of the waiver, delineated on pages 2-3 of the Special Terms and Conditions document (pa_termsandconditions.pdf), and consistent with Appendices A, B, and D.

beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees.

5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services.
6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions.
7. The cost for covering Premium Assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS.
8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services.
9. Premium assistance beneficiaries will have equal or better access to preventive care services.
10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided.
11. Premium assistance beneficiaries who are young adults eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefits will have at least as satisfactory and appropriate access to these benefits.
12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation.

The evaluation design, taking into account the four goals and 12 hypotheses outlined above, considers through its performance measures and analysis plan the coverage for the following dimensions of access and quality, as shown in Appendix A:

- Comparisons of provider networks;
- Consumer satisfaction and other indicators of consumer experience;
- Provider experience; and
- Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes.

Each of these four aspects of access and quality is associated with specific measures tied to the 12 research hypotheses and are listed in Appendix A. Appendix A illustrates the relationship between the research hypotheses and Demonstration goals, while Appendix B addresses the specific measures used to evaluate each of the 12 research hypotheses.

2. EVALUATION DESIGN

The core purpose of the evaluation is to determine the costs and effectiveness of the NHHPP PAP, when considered in its totality, and taking into account both initial and longer term costs and other impacts such as improvements in service delivery and health outcomes. The evaluation will explore and explain the effectiveness of the Demonstration for each research hypothesis, including total costs in accordance with the evaluation design as approved by CMS. As shown in Appendix B, each research hypothesis includes one or more evaluation measures. Wherever feasible, each measure will be in a standardized form comparable to and compared against national values.

Included in the evaluation will be examinations of NHHPP PAP performance on a set of access and clinical quality measures against a comparable population in the New Hampshire Medicaid Care Management Program. These measures will be taken from the list of required data fields for the claims submitted by each QHP for each PAP recipient. The State will compare costs (i.e., total, administrative, and medical) under the NHHPP Premium Assistance Demonstration to costs of what would have happened under a traditional Medicaid expansion. In this case, the evaluation will compare the costs of the PAP program to the estimated costs if that population would have remained in the Bridge program, which was created for Medicaid expansion.

The cost comparison will include an evaluation of provider rates, healthcare utilization and associated costs, and administrative expenses. The State will assess access and quality for the NHHPP PAP beneficiaries and Medicaid beneficiaries in managed care to ensure appropriate services are provided to the PAP beneficiaries. Moreover, to the extent possible, component contributions to changes in access and quality and their associated levels of investment in New Hampshire will be determined and compared to improvement efforts undertaken in other delivery systems.[4] Both cross-sectional and sequential cross-sectional analyses will be used, depending on the whether the measure is across one point in time or multiple points in time, along with the specific research hypothesis being addressed.

The operational details for the PAP evaluation are contained in the following four appendices:

- Appendix A – Evaluation Components
- Appendix B – Research Hypotheses, Groups, and Associated Methodologies
- Appendix C – Milestones and Timeline
- Appendix D – Rapid Cycle Assessment Measures

[4] To access and utilize administrative cost information, the non-encounter cost information will be generated by the State and provided to the evaluation contractor, as needed.

Before addressing the 12 research hypotheses and associated measures, the next section of the PAP evaluation plan defines the study and comparison groups, data sources, analytic methods, and limitations to the evaluation of the PAP Demonstration.

Study Population

The study population consists of all beneficiaries covered under Title XIX of the Social Security Act in the State of New Hampshire from 19 years through 64 years of age who are not medically frail, incarcerated, or enrolled in cost-effective employer sponsored insurance and who are enrolled in Medicaid managed care.[5] This study population will be divided into two groups to operationalize the evaluation—i.e., the study group and the comparison group.

Study Group

The study group is the NHHPP PAP group and consists of beneficiaries covered under Title XIX of the Social Security Act who are either:

1) Childless adults between the ages from 19 through 64 with incomes at or below 133 percent of the federal poverty level who are neither enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance or
2) Parents between the ages of 19 through 64 with incomes between 38 percent (for non-working parents) or 47 percent (for working parents) and 133 percent of the Federal Poverty Level and who are not enrolled in (or eligible for) Medicare, not incarcerated, not medically frail, or not eligible for cost-effective employer sponsored insurance

The NHHPP PAP membership is estimated to contain approximately 45,000 beneficiaries.[6]

Comparison Groups

Two comparison groups are needed for this evaluation. The sequential cross-sectional comparison group (used in longitudinal analyses) consists of newly eligible members of the Bridge Program, most of whom will be eligible for the PAP program the following year. The Bridge Program is a transition program that enrolled Medicaid expansion beneficiaries into New Hampshire's Medicaid managed care program beginning in

[5] Coverage and delivery of benefits to eligible members are consistent with section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR Section 435.119.

[6] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf , Page 9 of 146. Last accessed on May 28, 2015.

August 2014. Assuming these beneficiaries remain eligible, Bridge Program members will be automatically enrolled in the PAP program in January 2016 leading to substantial overlap between the two populations. As such, the Bridge Program comparison group includes members enrolled in the Bridge Program beginning in August 2014 through December 31, 2015.

The non-PAP comparison group for all measures, except those derived through survey instruments,[7] consists of a statistically matched group of Title XIX beneficiaries in the State in parent/caretaker eligibility groups from 19 through 64 years of age who are not in the study group, not disabled, or incarcerated, and who are enrolled in a Managed Care Organization (MCO), updated at each measurement time.[8] The comparison group is estimated to contain between 12,000 and 15,000 beneficiaries, depending upon the number lost through the statistical matching process.[9] This group provides a baseline frame of reference for expected changes over time to assess the PAP program and its changes over time in subsequent years, if the PAP is continued. The start for this group's data should coincide with the start of the Bridge Program and its data.

Specifically for the cost-effectiveness analyses, the comparison group will consist of a statistically derived cohort of beneficiaries and their estimated costs if the Bridge Program were continued. The analysis will estimate what this population would have cost if the Bridge program continued past December 31, 2015, adjusting for items such as medical cost trend, demographic differences, acuity differences, and changes to targeted Bridge program provider reimbursement levels.

The evaluation of the Demonstration will be performed using rigorous actuarial and statistical methods to assess whether the beneficiaries in the NHHPP PAP are doing as well or better than in the Bridge program on the various measures in the evaluation. The population enrolled in the Bridge program will have very similar characteristics to the population enrolled in the PAP program, but the methodology will also use statistical matching techniques to ensure the populations used for comparison are as similar as possible. The analysis will compared the actual experience of the Bridge program population (trended and adjusted to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program. The methodology will be designed to determine the extent to which observed differences are statistically significant and meaningful to assess the research goals of the Demonstration.

[7] The evaluation contractor may use the Consumer Assessment of Health Care Providers and Systems (CAHPS®) survey or CAHPS-like survey for the intended data source. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[8] Statistical matching will be validated through a discriminant analysis with power set at approximately .8 for the comparison between groups on a set of criteria determined in coordination with subject matter experts.

[9] Email from Andrew Chalsma, Office of Medicaid Business and Policy, New Hampshire Department of Health and Human Services to Debra L. Chotkevys, Director, Professional Services, Health Services Advisory Group, Inc., on May 27, 2015.

Data Sources

New Hampshire is in the process of finalizing Memorandums of Understanding (MOU) with the QHPs for their participation in the PAP. While the MOUs are not yet signed, the Department and the QHPs have agreed on the terms that require the QHPs to provide encounter data to the state. The QHPs will submit data to the Department using the format and quality requirements of the State's Comprehensive Health Care Information System (CHIS), New Hampshire's All Payer Claims Database. Because the submission of data to the CHIS is a legal requirement to be a carrier in New Hampshire, the QHPs are already obligated to process and format the data according to the CHIS requirements. Existing CHIS data quality assurance processes will be employed to ensure the data are complete and of high quality. The QHPs will need to submit a separate duplicate feed for PAP members, because the CHIS data normally contain encrypted identifiers. The separate CHIS-like file the QHPs will provide to the Department will contain identifiers including member Medicaid ID which will allow linking the data to Medicaid membership and claims.

DHHS and its evaluation contractor will use multiple sources of data to assess the 12 research hypotheses. The data collected will include both administrative and survey-based data (e.g., CAHPS, CAHPS-like, telephonic information gathering). Administrative data sources include information extracted from DHHS's Medicaid Management Information System (MMIS), the State's Comprehensive Health Care Information System (CHIS), and the State's All-payer Hospital database. The three data sources are used to collect, manage, and maintain Medicaid recipient files (i.e., eligibility, enrollment, and demographics), fee-for-service (FFS) claims, and managed care encounter data. These data bases serve as central repositories for significant portions of the data DHHS will use to mine, collect, and query while addressing the 12 research hypotheses. DHHS and its evaluation vendor will work together with key data owners to ensure the appropriate data use agreements are in place to obtain the data. Data sharing Memorandums of Understandings (MOU) will be initiated with entities to allow access to and use of Medicaid claims and encounters, member demographics and eligibility/enrollment, and provider data.

Administrative Data

New Hampshire's Demonstration evaluation offers an opportunity to synthesize information from several data sources to determine the impact of the NHHPP PAP. The administrative data sources—i.e., CHIS, MMIS (including member, provider, and enrollment data), the All-payer Hospital databases—are necessary to address the 12 research hypothesis outlined in the evaluation design. Each measure (see Appendix B) associated with each research hypothesis lists the data source(s) used in addressing it. Three key fields that must be present to conduct the evaluation include the date of birth (for defining the study populations and some individual measures), a flag to identify

whether a Medicaid recipient is enrolled in the PAP, and a flag to identify if the recipient is in a traditional Medicaid managed care.

Use of FFS claims and managed care encounters will be limited to final, paid status claims/ encounters. Interim transaction and voided records will be excluded from all evaluations, because these types of records introduce a level of uncertainty (from matching adjustments and third party liabilities to the index claims) that can impact reported rates.

CHIS

"The New Hampshire Comprehensive Health Care Information System (CHIS) was created by NH statute to make health care data 'available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.'"[10] The same legislation that created the CHIS also enacted statutes that mandated health insurance carriers to submit encrypted health care claims data and Health Employer Data and Information Set (HEDIS®[11]) data to the State. HEDIS® data will be collectd at the plan level. As a result, CHIS data will be useful in calculating several of the measures used in the Demonstration evaluation.

MMIS

Not all data required for the evaluation will be in the CHIS database. As such, access to Medicaid claims and encounters will be required to optimize the information available to calculate the various measures. In general, Medicaid encounters are received and processed by the State's fiscal agent on a weekly basis with a historical 'run-out' of three months. In addition to service utilization data, the NHHPP PAP evaluation will require access to supplemental Medicaid data contained in the State's MMIS—e.g., member demographics, eligibility/enrollment, and provider information.

New Hampshire Medicaid began processing managed care encounter data in July of 2015. New Hampshire is employing a three-fold strategy to ensure completeness and accuracy of the encounter data: 1) New Hampshire's Medicaid managed care contracts contain robust requirements for timeliness, completeness and accuracy with the possibility of liquidated damages if the standards are not met; 2) New Hampshire's encounter data processing solution pseudo adjudicates encounters through the State's MMIS applying many of the same quality edits employed for FFS claims; and 3) New Hampshire has availed itself of the optional EQRO activity of Encounter Data Validation (current EQRO contract includes activity and EQRO is currently implementing a EDI based solution for loading the data as part of validation). Because the processing of the data only began recently, NH does not yet have summary analysis

[10] New Hampshire Comprehensive Health Care Information System. https://nhchis.com, Last accessed on May 26, 2015.
[11] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

on data quality. However, NH is confident that their strategies will produce valid and reliable data and is committed to that outcome.

Member Demographics—Member data are used to assess member age, gender, and other demographic and economic information required for the calculation of specific measures. For example, member demographics are used to determine member's age in order to define the comparison group relative to the distribution of the population in the study group. Additionally, fields such as gender will be used for the prenatal and postpartum measures. Finally, key financial data will be used when assessing gaps in coverage.

Eligibility/Enrollment—The eligibility/enrollment file will also be used create the study and comparison groups, as well as the assessment of health insurance and enrollment gaps.

Provider—Provider data, such as office location and specialty, will be used to assess the availability of services for both study and comparison groups.

All-payer Hospital Data

All-payer Hospital Data will be used to generate baseline data on new enrollees to the NHHPP PAP. As newly enrolled members, data for this population will not be available in other State data sources since many of the NHHPP PAP beneficiaries will be new to Medicaid.

Consumer Surveys

CAHPS and/or CAHPS-like surveys will be used to assess satisfaction with provided health care services.[12] These instruments will include specific survey items designed to elicit information that address research hypotheses regarding members' continuity of health care coverage and health plan market diversity.

One option is for the State to work with New Hampshire's CAHPS vendor to seek approval from NCQA to supplement its annual CAHPS administration to include three evaluation-specific questions. These questions will be designed to capture elements of the waiver STCs that cannot be addressed through administrative data or currently collected survey items. These three items will address the following concepts:

1) Continuity in member health insurance coverage—research hypothesis 1 states that premium assistance beneficiaries will have equal or fewer gaps in health insurance coverage.

[12] Depending on the State's CAHPs vendor and survey logistics related to adding items to the annual CAHPS survey, DHHS may decide to administer a CAHP-like custom survey to maximize applicability to the study population and increase the likelihood of return.

2) Continuous access to the same health plan—research hypothesis 2 states that premium assistance beneficiaries will have access to the same health plans and maintain continuous access to the same providers.
3) Continuity in plan enrollment—research hypothesis 3 states that premium assistance beneficiaries will have equal or fewer gaps in plan enrollment leading to equal or greater continuity of care.

In choosing the potential responses for each of the three questions being proposed, the response categories will mimic other response categories used on the CAHPS form, such as the degree of respondent agreement with a statement or a Yes/No response. The final wording for each of the proposed items will be submitted to NCQA for review after collaboration with the State and its CAHPS vendor.

The CAHPS vendor is aware that the State is interested in comparing its Medicaid populations. For 2015, the CAHPS vendor has already prepared separate surveys for the NHHPP population and for the traditional Medicaid population. If the evaluation continues in successive years, the vendor will also separate the Medicaid population into three groups making the comparisons in this evaluation possible--i.e., the traditional managed care group, the NHHPP group, and the NHHPP PAP group.

An alternative option would be for the evaluation contractor to deploy an independent survey that is structured in a similar manner to CAHPS but could be administered in a more strategic and targeted manner than would normally be possible for CAHPS. This type of survey would capture the information required by each of the eight evaluation measures currently citing CAHPS as a potential data source.

Analytic Methods

The evaluation reporting will meet traditional standards of scientific and academic rigor, as appropriate and feasible for each aspect of the evaluation (e.g., for the evaluation design, data collection and analysis, and the interpretation and reporting of findings). The Demonstration evaluation will use the best available data, will use controls and adjustments where appropriate and available, and will report the limitations of data and the limitations' effects on interpreting the results. All research hypotheses and methods will incorporate results from sensitivity, specificity, and power analyses to ensure the validity of the evaluation findings. Lastly, the evaluation will discuss the generalizability of results in the context of the limitations.

As outlined earlier, the existence of the Bridge Program creates a unique comparison group for understanding various aspects of the Demonstration's research hypotheses. In order to ensure the appropriateness of comparisons, preliminary population profile reviews will be conducted on the Bridge and NHHPP PAP populations. These analyses will confirm key assumptions regarding the similarities and overlap in these populations on key demographic characteristics and serve as a foundation for future discriminant analyses and statistical matching. Furthermore, rates of enrollment (i.e., speed in

reaching the eligible populations) will be assessed and compared for the Bridge Program and NHHPP PAP populations. As a result of the unique transition from Bridge Program to NHHPP PAP program, two distinct approaches to the analyses will be used in order to maximize the retention of beneficiaries in each group over time. Specifically, the evaluation analyses will include the following methods.

1. **Cross-sectional Analysis:** These analyses examine results for selected measures for two different groups at the same point in time. For example, cross-sectional analyses will be used to evaluate NHHPP PAP members' access to certain services versus non-NHHPP PAP MCO members' access.
2. **Sequential, Cross-sectional Analysis:** These analyses will include both *single group* and *multiple group* evaluations of multiple measures over time. Single group evaluations involve pre- and post-testing of a population that is conceptually longitudinal but changes some percentage of its membership each year, such as the Medicaid population. Multiple group evaluations involve pre- and post-testing for all evaluation groups to create difference scores that are then compared across groups.

Both comparative methods will be used in the following NHHPP PAP evaluation. The specific choice of methods depends on the measure under discussion and the theoretical and empirical implications for policy-relevant and defensible results. For this reason, the specific comparative method is detailed within each of the measures used in the evaluation (See Appendix B and Appendix D). If the Demonstration is continued for an additional one or two years, the measures are also continued using the analogously extended groups (i.e., Bridge becomes NHHPP PAP and 'becomes' NHHPP PAP for three cycles of measurement).

The three main analytic methods used to determine whether the beneficiaries in the NHHPP PAP are doing as well or better than Medicaid beneficiaries in the traditional Medicaid managed care program on the various measures in the evaluation are the t-test, the z-test, and discriminant analysis. The t-test will be used for pre-post single group methods of assessment (e.g., sequential cross-sectional) as well as for cross-sectional comparisons of two groups at one point in time. A z-test will be used for comparative sequential cross-sectional designs where a difference-in-differences approach (i.e., absolute or relative) is applied, depending on the measures and scales used for their assessment. A discriminant analysis will also be used to ensure that Non-PAP comparison group is appropriately and statistically matched to the study population.

In situations where neither the t-test nor z-test is appropriate (e.g., a need to risk-adjust), a fourth method, multiple regression analysis, will be used to determine the size of group differences through the grouping variable in the model. This method has a long history of generating empirically robust results when the evaluation model is correctly specified. The evaluation contractor will utilize clinical subject matter experts (SMEs) when building multivariate models and identifying relevant control variables.

The cost-effectiveness portion of the evaluation examines costs in three ways: total and the medical and administrative components that, when summed, represent total healthcare costs. As a result, all costs (and credits) are required to fit into either the medical or the administrative category. Both of the cost-effectiveness measures are reported in these three ways. There are three annual measures (i.e., 3-3, 7-1, and 7-2) and three rapid-cycle quarterly measures (i.e., CEC-1, CEC-2, and CEC-3) used assess the cost-effectiveness of the Demonstration. To do so, the costs (i.e., total and breakdown for medical and administrative) will be tracked for comparing actual NHHPP PAP costs to the estimated costs if the Bridge program were continued. After evaluating the available data, these comparisons may be modified or additional cost effectiveness comparisons may be developed if they are deemed to further the research goals of the Demonstration.

Finally, where appropriate, supplemental analyses will be conducted to further investigate and understand the impact of the NHHPP PAP program. These analyses may include plan-based comparative findings as well as the stratification of results by key demographic and/or programmatic characteristics. When possible, evaluation results will incorporate national or state-defined standards and/or benchmarks for comparison purposes. Together, the findings from these sub-group analyses will further inform the State regarding the impact of the NHHPP PAP program.

Process/Outcome Measures

When possible, process measures will be used since they do not require any form of risk adjustment beyond eligibility. The reason is related to the nature of process measures in that the 'processes' are required for anyone who meets the inclusion and exclusion criteria for the measure. Theoretically, a process measure should be able to reach 100 percent among the eligible populations.

Outcome measures often require some form of risk adjustment or stratification. Certain demographic characteristics must be stratified for CMS reporting, such as race, rather than used as a risk-adjustment variable in a multivariate model. For comparison purposes, a comparison group is formed from the non-PAP MCO Medicaid beneficiaries such that a discriminant analysis with policy-relevant predictor variables cannot distinguish group membership beyond randomness, with statistical power set to approximately .8 for the comparison.

Comparative Statistics

The t-tests (and z-tests where appropriate) will be used to assess whether any differences found between the study and comparison groups are statistically significant (i.e., unlikely to have occurred in the data through random chance alone). The traditionally accepted risk of error ($p \leq .05$) will be used for all comparisons. If risk adjustment is used, p-values will be generated through multiple regression analysis and assessed against the same critical p-value.

Limitations

The limitations surrounding this evaluation center on the lack of truly comparative data for the NHHPP PAP members for outcome variables in the first year of the Demonstration beyond the All-payer Hospital data. When a new and empirically different group is added to Medicaid, there is often no comparison group with data to assess potential programmatic differences between the new group and the effects of joining the ongoing Medicaid program, instead. As a result, assumptions on comparability are sometimes made that lack empirical evidence for support or that have somewhat inconsistent evidence of comparability.

Additionally, little or no data will exist in sufficient time for the New Hampshire legislature to decide whether it will continue the NHHPP PAP past its first year of operation. This situation will require the State legislature to make program decisions without the knowledge and support of the first annual evaluation of the program, or from the interim evaluation conducted after full implementation of the Demonstration.

3. REPORTING

Following its annual evaluation of the NHHPP PAP and subsequent synthesis of the results, DHHS and its evaluation vendor will prepare a report of the findings and how the results compare to the research hypotheses. Both the interim annual reports and the final summative evaluation report will be produced in alignment with STCs and the schedule of deliverables listed in Table 1 below. (See Appendix C for a detailed timeline.) Following approval to continue the NHHPP PAP in Year 2 and Year3 by the New Hampshire State Legislature, the schedule of deliverables will be updated to reflect additional reporting requirements.

Table 1—Schedule of Deliverables for the NHHPP PAP Waiver Evaluation

Deliverable	Date
NHHPP PAP Evaluation Design (STC #66)	
DHHS submits PAP Waiver Evaluation Methodology to CMS	6/4/2015
DHHS to post PAP Waiver Evaluation Methodology on the State's website for public comment	6/4/2015
DHHS to post final approved Evaluation Design on the State's website within 30 days of approval by CMS	On or before 10/15/2015
DHHS presentation to CMS on approved Evaluation Design (STC #73)	As Requested
Demonstration Year 1	
Quarterly: DHHS to report progress of Demonstration to CMS (STC #82)	30 days after the quarter
If Demonstration Continued, Interim Annual Evaluation Report (STC #70)	3/31/2017
If Demonstration Ended, Preliminary Summative Evaluation Report (STC #71)	6/29/2017
If Demonstration Ended, Final Summative Evaluation Report (STC #71)	12/31/17
DHHS presentation to CMS on Final Summative Evaluation Report (STC #73)	As Requested

Each evaluation report will present findings in a clear, accurate, concise, and timely manner. At minimum, all written reports will include the following six sections: Executive Summary, Demonstration Description, Study Design, Findings and Conclusions, Policy Implications, and Interactions with Other State Initiatives. Specifically, the reports will address the following:

1) The **Executive Summary** concisely states the goals for the Demonstration, the evaluation questions and hypotheses tested in the report, and updates on questions and hypotheses scheduled for future reports. In presenting the key

findings, budget neutrality and cost-effectiveness will be placed in the context of policy-relevant implications and recommendations.

2) The **Demonstration Description** section focuses on programmatic goals and strategies, particularly related to budget neutrality and cost-effectiveness. The section succinctly traces the development of the program from the recognition of need to the present degree of implementation. This section will also include a discussion of the State's roll-out of the NHHPP PAP program along with its successes and challenges.

3) The **Study Design** section contains much of new information in the report. Its five sections include: evaluation design with the 12 research hypotheses and associated measures, along with the type of study design; impacted populations and stakeholders; data sources that include data collection field, documents, and collection agreements; analysis techniques with controls for differences in groups or with other State interventions, including sensitivity analyses when conducted; and limitations for the study.

4) The **Findings and Conclusions** section is a summary of the key findings and outcomes. The section focuses on cost-effectiveness, along with the successes, challenges, and lessons learned from the implementation of the Demonstration.

5) The **Policy Implications** section contains the policy-relevant and contextually appropriate interpretations of the conclusions. This section includes the existing and expected impact of the Demonstration within the health delivery system in the State in the context of the implications for State and federal health policy, including the potential for successful strategies to be replicated in other State Medicaid programs.

6) The **Interactions with Other State Initiatives** section contains a discussion of this Demonstration within an overall Medicaid context and consideration for the long-range planning efforts by the State. This discussion includes the interrelations between the Demonstration and other aspects of the State's Medicaid program, including interactions with other Medicaid waivers, the State Innovation Models (SIM) award, and other federal awards affecting service delivery, health outcomes, and the cost of care under Medicaid.

All reports, including the Evaluation Design, will be posted on the State Medicaid Website within 30 days of the approval of each document to ensure public access to evaluation documentation and to foster transparency. DHHS will notify CMS prior to publishing any results based on Demonstration evaluation for CMS' review and approval. The reports' appendices present more granular results and supplemental findings. The State will work with CMS to ensure the transmission of all required reports and documentation occurs within approved communication protocols.

Independent Entity

Based on State protocols, DHHS will follow established policies and procedures to acquire an independent entity or entities to conduct the NHHPP PAP Demonstration evaluation. The State will either undertake a competitive procurement for the evaluator or will contract with entities that have an existing contract relationship with the State. An assessment of potential vendors' experience, knowledge of State programs and populations, and resource requirements will determine selection of the final candidate, including steps to identify and/or mitigate any conflicts of interest.

Budget

Due to the complexity and resource requirements of the NHHPP PAP Demonstration, DHHS will need to conduct a competitive procurement to obtain the services of an independent entity to perform the services outlined in this evaluation design. As such, an estimated budget is currently unavailable and will be determined through the competitive bid process. Upon selection of an evaluation vendor, a final budget will be prepared in collaboration with the selected independent entity. Table 2 displays the proposed budget shell that will be used for submitting total costs for the Demonstration. Costs are broken out by staff, estimated hours, costs, and anticipated subcontractors. At this time, DHHS is working with its Actuarial vendor to secure their assistance in preparing all cost-related measures.

Table 2—Proposed Budget Template for NHHPP PAP			
	Year X (January 2016-2017)		
Staff Title	*Loaded Rate*	*Hours*	*Total*
Executive Director, Research & Analysis			
Project Director, Research & Analysis			
Project Director			
Project Manager			
Project Support			
Analyst			
Database Developer			
Reports Team			
Subtotal Direct and Indirect Costs			
Subcontractor - Statistician			
Subcontractor –Survey Vendor			

Subcontractor – Actuarial Vendor			
Annual Total			

As noted earlier, the costs presented in Table 2 will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning analyses and report generation. A final budget will be submitted once a final evaluation contractor has been selected.

5. APPENDIX A: EVALUATION COMPONENTS

PAP Waiver Goal[1]	Hypothesis Being Addressed[13]	Dimension of Access and/or Quality[14]
1. Continuity of coverage - For individuals whose incomes fluctuate, the Demonstration will permit continuity of health plans and provider networks	1. Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage	Comparisons of provider networks
	2. Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers	Provider experience
2. Plan Variety - The Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts	3. Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower administrative costs	Evidence of improved access and quality across the continuum of coverage and related health outcomes
	4. The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts	Comparisons of provider networks over time.
3. Cost-effective Coverage - The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs	5. Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	6. Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	7. The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS	Comparisons of provider networks
4. Uniform provider access - The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration to determine if it is comparable to the access afforded to the general population in New Hampshire	8. Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	9. Premium assistance beneficiaries will have equal or better access to preventive care services	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	10. Premium assistance beneficiaries will report equal or better satisfaction in the care provided	Consumer satisfaction and other indicators of consumer experience
	11. Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes
	12. Premium assistance beneficiaries will have appropriate access to non-emergency transportation	Evidence of equal or improved access and quality across the continuum of coverage and related health outcomes

[13] New Hampshire Health Protection Program Premium Assistance. New Hampshire Department of Health and Human Services. http://www.dhhs.nh.gov/pap-1115-waiver/documents/final-waiver-app-11202014.pdf, Page 10 of 146. Last accessed on May 26, 2015.

[14] ibid, STC #69.1.a.

6. APPENDIX B: EVALUATION RESEARCH HYPOTHESES AND MEASURES

The 12 research hypotheses are grouped according to the four waiver goals delineated in Appendix A. The definitions presented below are generally quoted from Section II. Program Description and Objectives in the Special Terms and Conditions document.[15] Numbering of the individual research hypotheses from STC #69 is changed herein to correspond with the goals of the waiver shown in Appendix A.

Continuity of Coverage

Definition: For individuals whose incomes fluctuate, the NHHPP PAP Demonstration will permit continuity of health plans and provider networks. Individuals and families may receive coverage through the same health plans and seek treatment and services through the same providers regardless of whether their underlying coverage is financed by Medicaid or through the Marketplace. The State will evaluate whether individuals remain in the same QHP when Medicaid payment is terminated.

Hypothesis 1: ***Premium assistance beneficiaries will have equal or fewer gaps in insurance coverage***

Gaps in insurance coverage decrease the potential for preventive care and, therefore, increase the potential for more expensive emergency and/or inpatient care. Due to the insurance premiums being paid by New Hampshire for eligible beneficiaries, any gaps in coverage should be for income level changes, moving out of State, aging out, death, incarceration, or other situation beyond the control of the State for ensuring continuous insurance coverage.

Measure 1-1	Continuity in Member Health Insurance Coverage
Definition:	The average number of gaps in insurance coverage
Technical Specifications:	The average number of gaps in insurance coverage per 100 members enrolled in PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[15] pa_termsandconditions.pdf

Measure 1-2	Continuity in Member Health Insurance Coverage
Definition:	The percentage of eligible members with gaps in insurance coverage
Technical Specifications:	The percentage of eligible members with gaps in insurance coverage, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 1-3	Patient Perspective on Continuity in Health Insurance Coverage
Definition:	Patient perspective on the continuity of health insurance coverage
Technical Specifications:	Eligible recipients will be surveyed to whether the members reported being without health insurance during the previous six months. "In the last six months, were you without health insurance at any time?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3[16]
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

[16] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.

Hypothesis 2: ***Premium assistance beneficiaries will maintain continuous access to the same health plans, and will maintain continuous access to providers***

This two-part research hypothesis examines continuity of care within health plans and continuous access to providers associated with the member's health plan. For this research hypothesis, the providers are the groups of PCPs delivering care to the MCO's members. With the State paying for the beneficiaries' premiums, the intent is that members will see the same group of providers as least as commonly as the comparison group members.

Measure 2-1	Continuous Access to the Same Health Plan
Definition:	The percentage of eligible members with continuous access to the same health plan for the measurement year
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to the same health plan during the measurement period – one plan the entire time.
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 2-2	Patient Perspective on Continuity in Same Plan Coverage
Definition:	Patient perspective on continuous access to the same health care plan
Technical Specifications:	Eligible recipients will be surveyed to whether the members had continuous access to the same health care plan during the previous six months. "In the last six months, did you have to switch to a different health care plan?" (Use CAHPS' standard Yes/No response categories and format)
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	Additional CAHPS or CAHPS-like question modeled after CAHPS 5.0 Item 3
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.

National Benchmark:	None

Measure 2-3	Patient Perspective on Continuous Access to Providers
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor's office or clinic as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q6
Exclusion Criteria:	Subject to income level qualifications
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 2-4	Numbers of Medically Frail Self-Declarations
Definition:	The number of PAP members each year who self-declare as medically frail.
Technical Specifications:	The number of PAP members each year who self-declare as medically frail and leave the PAP population.
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	Annual, if the Demonstration is continued
Comparison Method(s):	None
National Benchmark:	None

Plan Variety

Definition: The NHHPP PAP Demonstration could also encourage Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and could encourage QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace would afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and would increase the selection of plans for both Medicaid and Marketplace enrollees. The State will evaluate whether there is an increase in the number of available QHPs because of this potential for dual participation.

Hypothesis 3: ***Premium assistance beneficiaries, including those who become eligible for Exchange Marketplace coverage, will have equal or fewer gaps in plan enrollment, equal or improved continuity of care, and resultant equal or lower***

administrative costs

Beyond the continuity of insurance coverage previously addressed, this research hypothesis examines gaps in actual enrollment, the empirical continuity of care, and the administrative costs of care. If the NHHPP PAP functions as designed, actual enrollment should be at least as continuous as for the beneficiaries in the comparison group, their continuity of care should be at least as good due to improved access, and the overall administrative costs should decrease through knowledge of premium costs weighed against the costs in the comparison group. Three measures will, in combination, be used to assess this research hypothesis.

Measure 3-1	Continuity in Plan Enrollment
Definition:	The average number of gaps in enrollment from any Medicaid plan
Technical Specifications:	The average number of gaps in enrollment of any kind from any Medicaid MCO or PAP plan per 100 enrollee years, PAP versus traditional Medicaid MCO coverage during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State Eligibility and Enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-2	Continuity in Plan Enrollment
Definition:	Percentage of eligible members with continuous health plan access
Technical Specifications:	The percentage of eligible members enrolled in PAP versus traditional Medicaid MCO coverage with continuous access to any Medicaid MCO or PAP health plan during the measurement period
Exclusion Criteria:	Subject to income level qualifications, incarceration, and other relevant programmatic restrictions
Data Source(s):	State eligibility and enrollment databases
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 3-3	Patient Perspective on Continuity of Care
Definition:	The cornerstone of continuity of care is in knowing one's PCP. For this reason, this portion of the research hypothesis is defined through whether the beneficiary has a personal doctor. For respondents, this item is defined as the proportional choice for "A personal doctor is the one you would see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?" for responses 'Yes' or 'No'.
Technical Specifications:	CAHPS – Access: Getting Needed Care, CAHPS 5.0 Item Q10
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 3-4	Members' Administrative Cost (Total Costs and Medical Costs Captured in Research Hypotheses 7-1 and 7-2)
Definition:	Administrative per member per month (PMPM) cost
Technical Specifications:	Annual administrative costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Hypothesis 4: ***The Demonstration could lead to an increase in plan variety by encouraging Medicaid Care Management carriers to offer QHPs in the Marketplace in order to retain Medicaid market share, and encouraging QHP carriers to seek Medicaid managed care contracts. This dual participation in the Medicaid Care Management program and the Marketplace could afford beneficiaries seamless coverage during times of transition either across eligibility groups within Medicaid or from Medicaid to the Marketplace, and could increase the selection of plans for both Medicaid and Marketplace enrollees***

The idea supporting this research hypothesis is that market forces will take note of the influx of covered beneficiaries from the NHHPP PAP and will compete for market share. If the intended effect materializes, one benefit might be seamless transitions between the traditional marketplace and the NHHPP PAP. Beneficiaries might see an advantage to belonging to plans offering both types of coverage, which then might increase the total number of plans competing for market share and the potential of dual participation.

Measure 4-1	Medicaid Care Management Carriers Offering QHPs in the Marketplace
Definition:	Desk audit for the number of Medicaid Care Management carriers offering QHPs in the Marketplace at the start of the waiver and annually thereafter for which dual participation could be an option
Technical Specifications:	Count of the number of Medicaid Care Management carriers offering QHPs in the Marketplace for which dual participation could be an option
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None
Measure 4-2	**QHPs in the Marketplace Offering Medicaid MCO Plans**
Definition:	Desk audit for the number of QHPs for PAP enrollees in the Marketplace offering Medicaid MCO Plans at the start of the waiver and annually thereafter
Technical Specifications:	Count of the number of QHPs in the Marketplace offering Medicaid MCO Plans
Data Source(s):	Administrative survey
Comparison Group(s):	1. Bridge to PAP and PAP annually thereafter, if continued
Comparison Method(s):	Report the results for both groups in paneled format.
National Benchmark:	None

Cost-effective Coverage

Definition: The premium assistance approach will increase QHP enrollment and may result in greater economies of scale and competition among QHPs. This, in turn, may result in coverage that achieves cost reductions in comparison to traditional Medicaid managed care coverage. The State will evaluate whether QHP coverage is cost-effective, looking at the entire NHHPP PAP Demonstration period and trends that emerge as it proceeds.

Hypothesis 5: ***Premium assistance beneficiaries will have equal or lower non-emergent use of emergency room services***

'Non-emergent use' is interpreted to mean that the service could have been appropriately delivered at a lower level, such as an urgent care clinic or at a PCP's office. One of the intended functions of the NHHPP PAP is to treat beneficiaries in the appropriate setting, which is often the PCP's office. The appropriate setting is frequently less expensive and provides more local access than is found with non-emergent use of emergency room services.

Measure 5-1	Ambulatory Care: Emergency Department Visits Potentially Treatable in Primary Care by Eligibility Group
Definition:	Ambulatory emergency department visits for conditions potentially treatable in primary care per 1,000 member months by eligibility group
Technical Specifications:	AMBCARE.09 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf[17]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 6: ***Premium assistance beneficiaries will have equal or lower rates of potentially preventable emergency department and hospital admissions***

'Potentially preventable' in operationalized as ambulatory sensitive conditions, suggesting that more timely PCP care could have prevented the admission, rather than the admission being at too high a level of service, distinguishing the research hypothesis from research hypothesis 5. For example, emergency room use and/or hospitalization for complications from the flu are potentially preventable with influenza and pneumococcal immunizations, as appropriate.

Measure 6-1	Inpatient Hospital Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members
Definition:	Quarterly rate of inpatient hospital utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members

[17] NH Medicaid Care Management Quality Oversight Health Plan Reporting Specifications – V2.3

Technical Specifications:	HPP_INPASC.01 - NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Measure 6-2	**Emergency Department Utilization for Ambulatory Care Sensitive Conditions for Adult Medicaid Members**
Definition:	Quarterly rate of emergency department utilization for ambulatory care sensitive conditions for overall Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI) Composite per 1,000 adult Medicaid members
Technical Specifications:	Analogous to HPP_INPASC.01, but in the Emergency Department setting
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 7: ***The cost for covering premium assistance beneficiaries will be comparable to what the costs would have been for covering the same expansion group in New Hampshire Medicaid in accordance with STC #69 on determining cost-effectiveness and other requirements in the evaluation design as approved by CMS***

This research hypothesis examines the relative costs in a comparative format between the more traditional Medicaid managed care program comprised of the comparison group and the new beneficiary program comprised of the study group. By knowing the premiums in advance, the State can make comparisons with the costs for non-premium assistance beneficiaries to ensure that the new beneficiaries in the NHHPP PAP will not cost New Hampshire more than if the State had enrolled the expansion group in the more traditional Medicaid managed care program comprising the comparison group.[18]

Measure 7-1	**Total Costs by Group**
Definition:	Total per member per month (PMPM) cost
Technical Specifications:	Annual total costs divided by total number of member months, calculated separately for the study and comparison groups

[18] Administrative costs are captured in research hypothesis 3.

Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Measure 7-2	**Medical Costs by Group**
Definition:	Annual per member per month (PMPM) cost
Technical Specifications:	Annual medical costs divided by total number of member months, calculated separately for the study and comparison groups
Data Source(s):	Milliman
Comparison Group(s):	Bridge to Actual PAP costs compared to estimated costs if the Bridge program were continued
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.
National Benchmark:	None

Uniform Provider Access

Definition: The State will evaluate access to primary, specialty, and behavioral health care services for beneficiaries in the NHHPP PAP Demonstration to determine if it is comparable to the access afforded to the general Medicaid managed care population in New Hampshire.

Hypothesis 8: ***Premium assistance beneficiaries will have equal or better access to care, including primary care and specialty physician networks and services***

One critical feature of the NHHPP PAP is the contracted QHPs' ability to deliver appropriate access to care through the availability of primary care and specialty physicians and associated services. The research hypothesis examines the extent to which the NHHPP PAP is successful in maintaining the access and services found in the traditional Medicaid managed care program.

Measure 8-1	Medication Management for People with Asthma (MMA)[19]
Definition:	The percentage of members 19–64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on for at least 75% of their treatment period
Technical Specifications:	State-modified HEDIS specifications[20]
Exclusion Criteria:	Diagnosis of emphysema, chronic obstructive pulmonary disease (COPD), obstructive chronic bronchitis, cystic fibrosis, acute respiratory failure, or members who have no asthma controller medications dispensed during the measurement year
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-2	Timeliness of Prenatal Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received prenatal care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.01 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

[19] The presented specifications are derived from the NCQA HEDIS 2015 Technical Specifications, Volume 2.
[20] HEDIS has some specifications that extend beyond the age range for the PAP program and are, therefore, State-modified to account for the age range difference.

Measure 8-3	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year who received postpartum care according to HEDIS specifications for the measure
Technical Specifications:	HEDIS_PPC.02 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 8-4	Patients' Perception of Ease of Getting Appointments with Specialists
Definition:	For respondents, a proportional choice for "In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q18, CAHPS 5.0[21]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Measure 8-5	Patients' Perception of Quick Access to Needed Care
Definition:	For respondents, a proportional choice for "In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?" for responses "Never / Sometimes / Usually / Always"
Technical Specifications:	CAHPS – Access: Getting Needed Care, Item Q4, CAHPS 5.0[22]
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison	1. Two-group t-test.

[21] CAHPS® Health Plan Surveys, Version: Adult Medicaid Survey 5.0, English.
[22] Ibid.

Measure 8-5	Patients' Perception of Quick Access to Needed Care
Method(s):	2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS benchmarks

Hypothesis 9: ***Premium assistance beneficiaries will have equal or better access to preventive care services***

Access to preventive care services is important for several reasons, as already seen through previous research hypotheses. Preventive services can help to maintain health and avoid more expensive emergency department use or hospitalization and are an important aspect of restraining the growth in the cost of providing health care. This research hypothesis evaluates access to preventive services.

Measure 9-1	Annual Access to (use of) Preventive/Ambulatory Health Services Adults by Age Group (i.e., 20-44, 45-64)
Definition:	The percentage of eligible members, age 20 years through 64 years, who had an ambulatory or preventive care visit, by age group
Technical Specifications:	HEDIS_AAP - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid managed care national rates

Measure 9-2	Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)
Definition:	The percentage of discharges for members 19 years through 64 years who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge
Technical Specifications:	HEDIS_FUH.01 - State-modified HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-3	Annual Influenza Immunization, 19-64
Definition:	Flu vaccinations for adults ages 19 to 64: percentage of members 18 to 64 years of age who received an influenza vaccination between July 1 of the measurement year and the date on which the CAHPS 5.0 survey was completed
Technical Specifications:	NCQA
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-4:	Comprehensive Diabetes Care - Eye Exam
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who had an eye exam (retinal exam) performed
Technical Specifications:	HEDIS_CDC.05 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-5	Comprehensive Diabetes Care - Medical Attention for Nephropathy
Definition:	The percentage of patients 19 to 64 years of age with type 1 or type 2 diabetes who received medical attention for nephropathy
Technical Specifications:	HEDIS_CDC.06 – State-modified specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-6	Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Definition:	The percentage of members 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received appropriate spirometry testing to confirm the diagnosis.
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-7	Mental Health Utilization - 1
Definition:	Mental health inpatient discharges
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-8	Mental Health Utilization - 2
Definition:	Mental health inpatient average length of stay
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Measure 9-9	Diabetes Monitoring for People With Diabetes and Schizophrenia
Definition:	The percentage of members 18 – 64 years of age with schizophrenia and diabetes who had both an LDL-C test and an HbA1c test during the measurement year
Technical Specifications:	HEDIS specifications
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test.

	2. Two-group z-test for differences in amounts of change.
National Benchmark:	HEDIS Medicaid Managed Care national rates

Hypothesis 10: *Premium assistance beneficiaries will report equal or better satisfaction in the care provided*

Patient-centered health care is important for many reasons, not the least of which is the relationship between greater satisfaction and low costs of care. Patients tend to utilize preventive services and follow medical advice more often when they are satisfied with the care they receive. For that reason, this research hypothesis compares the satisfaction of the more traditional Medicaid managed care beneficiaries for their provided care with that of the NHHPP PAP beneficiaries.

Measure 10-1	Patients' Rating of Overall Health Care
Definition:	For respondents, a proportional choice for "Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your health care in the last 12 months?"
Technical Specifications:	CAHPS 5.0 specifications, Q8
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Measure 10-2	Patients' Rating the Health Plan
Definition:	For respondents, "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?"
Technical Specifications:	CAHPS 5.0 specifications, Q26
Data Source(s):	CAHPS or CAHPS-like survey
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. Traditional Medicaid MCO to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	Potentially CAHPS

Hypothesis 11: *Premium assistance beneficiaries who are young adults eligible for EPSDT benefits will have at least as satisfactory and appropriate access to these benefits*

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are important to maintain health, catch illness early, and prevent disease when possible. The medically recommended schedule for these services continues until the beneficiary's 21st birthday. This research hypothesis examines the extent to which premium assistance beneficiaries 19 and 20 years of age received these services compared with the comparison group.

Measure 11-1	EPSDT Screening
Definition:	Total eligible beneficiaries who received at least one initial or periodic Screen
Technical Specifications:	EPSDT.06 – NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

Hypothesis 12: *Premium assistance beneficiaries will have appropriate access to non-emergency transportation (NEMT)*

Non-emergency transportation services support timely access to care at the appropriate level of care, which helps to reduce cost, as discussed in previous research hypotheses. This research hypothesis seeks to ensure that premium assistance members maintain appropriate access to non-emergency transportation services.

Measure 12-1	NEMT Request Authorization Approval Rate by Mode of Transportation
Definition:	The percentage of NEMT requests authorized, of those requested during the measure data period, by mode of transportation (i.e., contracted transportation provider - non-wheelchair van, volunteer driver, member, public transportation, wheelchair van, other), for the eligible population
Technical Specifications:	NH specifications for HPP_NEMT.06 (including A-F)[23]
Data Source(s):	CHIS, Medicaid claims, and encounter data
Comparison Group(s):	1. Bridge to PAP 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	1. Two-group t-test. 2. Two-group z-test for differences in amounts of change.
National Benchmark:	None

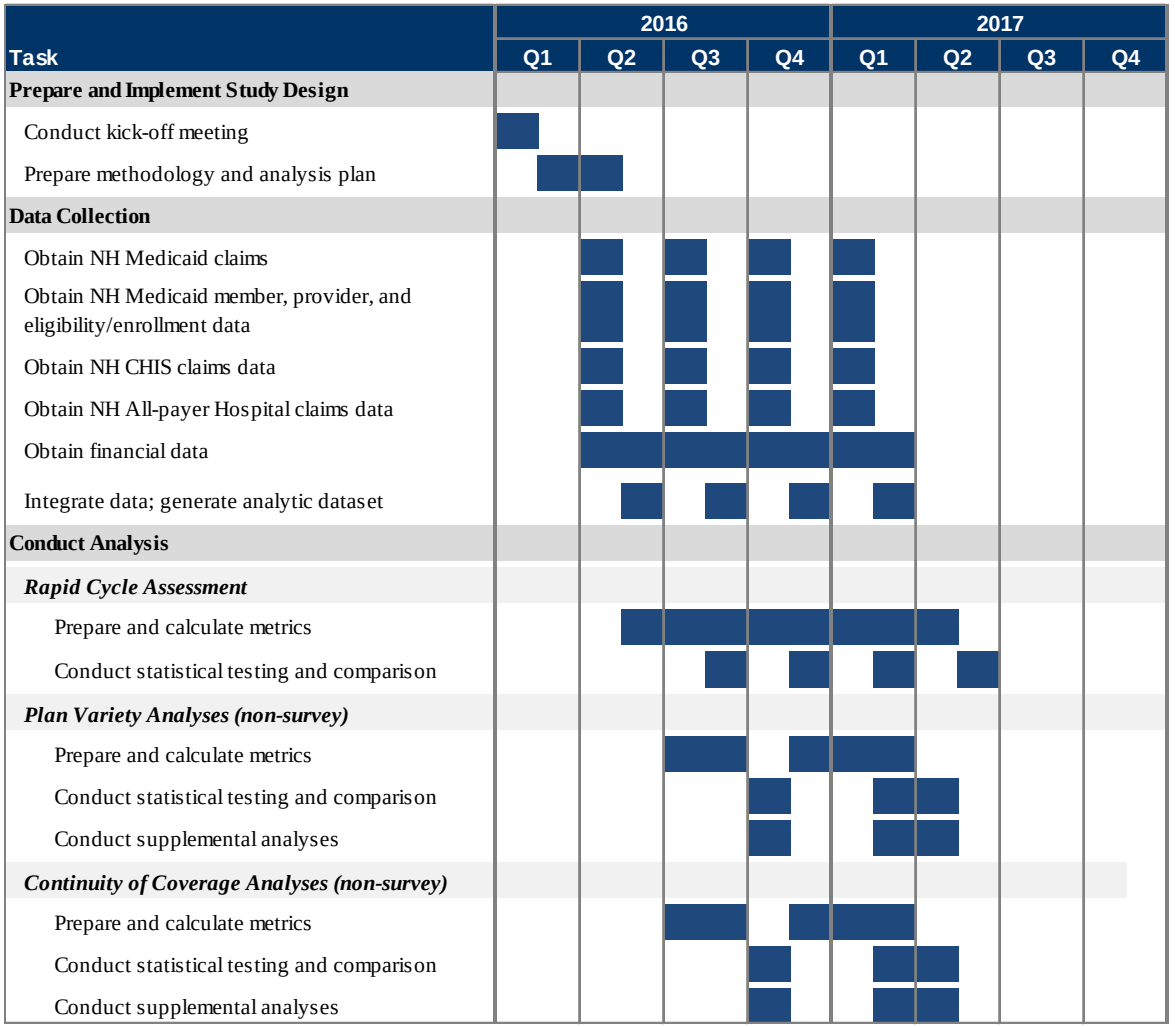
[23] New Hampshire Medicaid Quality Information System (MQIS), Specifications, Non-Emergent Transportation - NH Health Protection Program, Version 1.0, Published March 31, 2015.

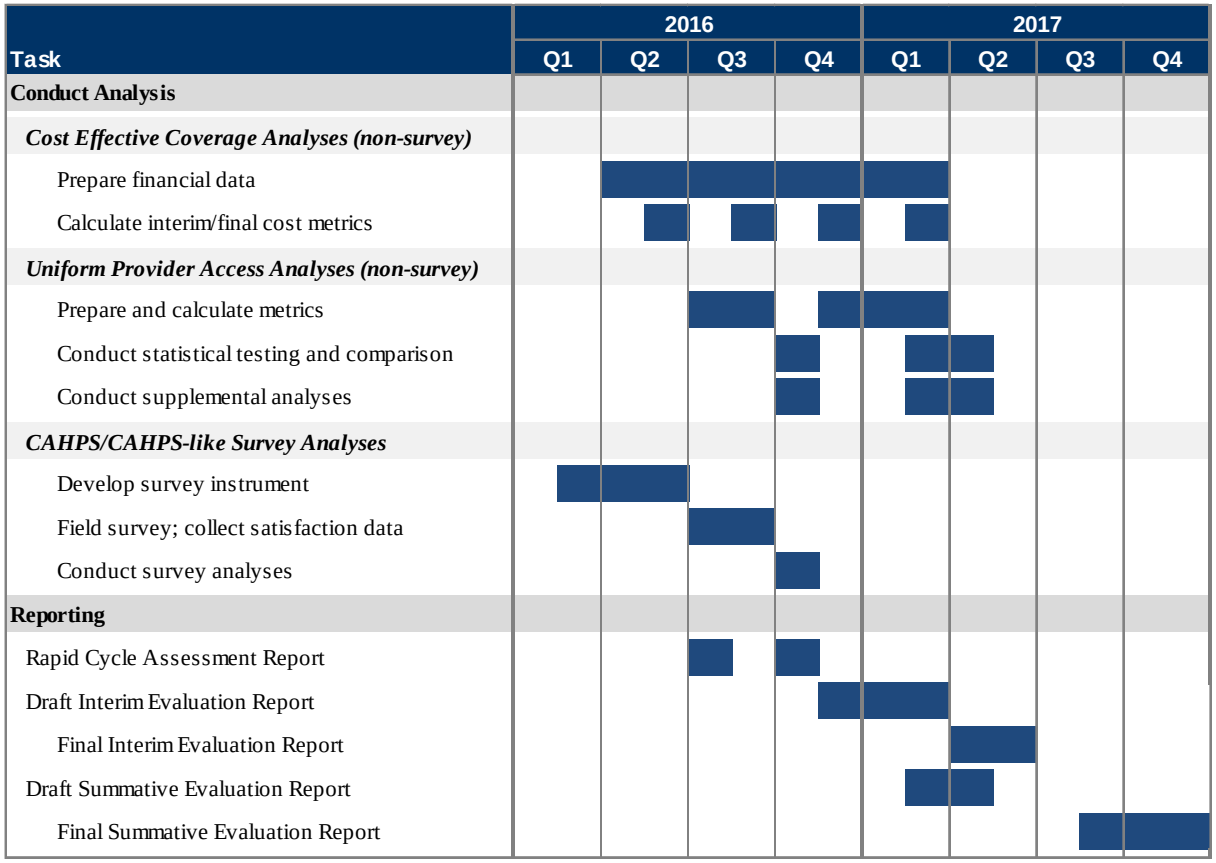
7. APPENDIX C: EVALUATION TIMELINE

The following project timeline has been prepared for the Demonstration evaluation outlined in the preceding sections. This timeline should be considered preliminary and subject to change based upon approval of the Evaluation Design and implementation of the NHHPP PAP. A final detailed timeline will be developed upon selection of the Independent Entity tasked with conducting the evaluation.

Figure C- 1 outlines the proposed timeline and tasks for conducting the NHHPP PAP evaluation.

Figure C-1—NHHPP PAP Evaluation Project Timeline


Task
2016
2017
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Prepare and Implement Study Design
Conduct kick-off meeting
Prepare methodology and analysis plan
Data Collection
Obtain NH Medicaid claims
Obtain NH Medicaid member, provider, and eligibility/enrollment data
Obtain NH CHIS claims data
Obtain NH All-payer Hospital claims data
Obtain financial data
Integrate data; generate analytic dataset
Conduct Analysis
Rapid Cycle Assessment
Prepare and calculate metrics
Conduct statistical testing and comparison
Plan Variety Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses
Continuity of Coverage Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses


Task
2016
2017
Q1
Q2
Q3
Q4
Q1
Q2
Q3
Q4
Conduct Analysis
Cost Effective Coverage Analyses (non-survey)
Prepare financial data
Calculate interim/final cost metrics
Uniform Provider Access Analyses (non-survey)
Prepare and calculate metrics
Conduct statistical testing and comparison
Conduct supplemental analyses
CAHPS/CAHPS-like Survey Analyses
Develop survey instrument
Field survey; collect satisfaction data
Conduct survey analyses
Reporting
Rapid Cycle Assessment Report
Draft Interim Evaluation Report
Final Interim Evaluation Report
Draft Summative Evaluation Report
Final Summative Evaluation Report

8. APPENDIX D: RAPID-CYCLE ASSESSMENT MEASURES

Continuity of Coverage (COC)

From a policy perspective in public health, continuity of coverage (COC) begins at the onset of available coverage (i.e., January 1, 2016, for NHHPP PAP members), rather than once coverage has been secured at a potentially later date. By definition, therefore, the 45,000 New Hampshire residents who are eligible for NHHPP PAP coverage before January 1, 2016,[24] and have NHHPP PAP coverage on January 1, 2016, have started continuity of coverage on time and do not have a *de facto* gap at the start of their available coverage.

Measure COC-1	Cumulative Initiation of Continuity in Member Health Insurance Coverage
Definition:	The cumulative number of NHHPP PAP beneficiaries with initiated coverage
Technical Specifications:	The total (i.e., sum) of the number of NHHPP PAP beneficiaries per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Measure COC-2	Proportional Initiation of Continuity in Member Health Insurance Coverage
Definition:	The proportion of the expected population of NHHPP PAP beneficiaries who have initiated coverage
Technical Specifications:	The ratio of the total (i.e., sum) of the number of NHHPP PAP beneficiaries to the 45,000 eligible people per month for the first three months of the program for whom health insurance coverage was paid by the State
Data Source(s):	Enrollment and finance databases
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

[24] New Hampshire Health Protection Program, Premium Assistance, Section 1115, Research and Demonstration Waiver, Final Application, November 7, 2014, Section 1, page 2

Plan Variety (PV)

One intended outcome of the NHHPP PAP is to motivate private insurers to create a dual participation in the Medicaid Care Management program and the Marketplace. This dual participation would afford Medicaid beneficiaries with seamless coverage during times of transition, either across eligibility groups within Medicaid or from Medicaid to the Marketplace. From a rapid cycle perspective, the policy relevant outcome would be an increase in dual participation insurers.

Measure PV-1	Dual Participation Providers
Definition:	The number of dual participation providers
Technical Specifications:	The quarterly number of dual participation providers from the implementation of the potential for dual participation on November 1, 2015 through April 30, 2016 and quarterly thereafter
Data Source(s):	Administrative review
Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.

Cost-effective Coverage (CEC)

One of the intended consequences of the premium assistance approach is to increase QHP enrollment and, therefore, result in greater economies of scale and competition among QHPs, lowering PMPM costs for Medicaid coverage.

Measure CEC-1	Total PMPM Total Cost - Quarterly
Definition:	Total per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly total costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-2	Medical PMPM Total Cost - Quarterly
Definition:	Medical per member per month (PMPM) cost, reported quarterly

Technical Specifications:	Monthly medical costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Measure CEC-3	Administrative PMPM Total Cost - Quarterly
Definition:	Administrative per member per month (PMPM) cost, reported quarterly
Technical Specifications:	Monthly administrative costs divided by total number of member months, calculated separately for the study and comparison groups, reported quarterly
Data Source(s):	Milliman
Comparison Group(s):	Bridge to PAP
Comparison Method(s):	Compare the actual experience of the Bridge program population (trended and adjusted for demographic changes, acuity differences, and reimbursement changes to estimate what this population would have cost if the Bridge program continued past December 31, 2015) to the actual experience of the PAP program.

Uniform Provider Access (UPA)

One of the requirements for the NHHPP PAP is that it should provide equal or better access to primary, specialty, and behavioral health care services for beneficiaries in the Demonstration. One performance measure that has the potential not only to be available to rapid fire assessment, but could also touch on all three settings for uniform provider assess (i.e., primary, specialty, and behavioral health care services), is postpartum care. Regardless of how long the beneficiary has been enrolled in the NHHPP PAP, postpartum care is a valid measure of uniform provider access.

Measure UPA-1	Postpartum Care
Definition:	For women, the percentage of deliveries of live births between each quarter who received timely and appropriate postpartum care
Technical Specifications:	HEDIS_PPC.02 – modified from NH Medicaid Reporting Specification, MCO-V2.3-01-05-15.pdf to be reported quarterly
Data Source(s):	All-payer Hospital, CHIS, Medicaid claims, and encounter data

Comparison Group(s):	1. Bridge to PAP: 2. Bridge to PAP vs. matched group to itself
Comparison Method(s):	Report the results for groups and comparisons in paneled format.